DENTAL ENROLLMENT FORM

DATE: ____________ DATE NEEDED: ____________

SHIP TO: ☐ PATIENT ☐ OFFICE

PATIENT INFO

NAME ____________ E-MAIL ____________ DOB ____________ ☐ MALE ☐ FEMALE

ADDRESS ____________ CITY ____________ STATE ______ ZIP ______

HOME TELEPHONE ____________ MOBILE PHONE ____________ SS# ____________

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

PRESCRIPTION INFORMATION

Commonly Requested Compounding Ideas

DRUG	DIRECTIONS	QUANTITY	REFILLS
☐ Profound Gel - Lidocaine 10%, Prilocaine 10%, Tetracaine 4%	☐ Apply 2ml to dried mucosal surface and leave in place for 3 minutes prior to procedure. ☐ Other: ____________	☐ ______ ☐ #_____2ml Oral Syringes	
☐ Profound Lite Gel - Lidocaine 5%, Prilocaine 5%, Tetracaine 4%	☐ Apply 2ml to dried mucosal surface and leave in place for 3 minutes prior to procedure. ☐ Other: ____________	☐ ______ ☐ #_____2ml Oral Syringes	
☐ Profound PE Gel - Lidocaine 10%, Prilocaine 10%, Tetracaine 4%, Phenylephrine 2%	☐ Apply 2ml to dried mucosal surface and leave in place for 3 minutes prior to procedure ☐ Other: ____________	☐ ______ ☐ #_____2ml Oral Syringes	
☐ TAC Alternate Gel - Lidocaine 20%, Tetracaine 4%, Phenylephrine 2%	☐ Apply 2ml to dried mucosal surface and leave in place for 3 minutes prior to procedure ☐ Other: ____________	☐ ______ ☐ #_____2ml Oral Syringes	
☐ Cyclone - Dyclonine HCl 0.5% and 1% Solution	☐ Gargle/Swish 30ml for 1 minute and rinse mouth 3 to 10 minutes prior to procedure ☐ Other: ____________	☐ ______ ☐ #____30ml Bottles	
☐ Lidocaine 2%/Chlorhexidine Gluconate 1.11% Oral Rinse	☐ Other: ____________ ☐ Swish 15ml in mouth and expel twice daily.	☐ _16oz____	
☐ Amitriptyline 4mg Troche	☐ Other: ____________ ☐ Dissolve 1 troche in mouth every 6 hours as need for pain.	☐ ___#_____	
☐ Tranexamic Acid 4.8% Mouthwash	☐ Other: ____________ ☐ Irrigate surgical area with 10ml before sutures. After surgery rinse with 10ml for 2 minutes and expel, four times a day..	☐ 120ml____	
☐ ____________	☐ Other: ____________	☐ ______	
☐ ____________	☐ Other: ____________	☐ ______	

Notes:

PRESCRIBER INFORMATION

Prescriber's Name: ____________ Contact Person: ____________

Telephone: ____________ Fax: ____________ Email: ____________

Office Address: ____________ City: ____________ State: ______ Zip: ______

NPI # : ____________ DEA # : ____________ TAX ID # : ____________ Medicaid Provider # : ____________

____________ ____________ * ____________

PRESCRIBER'S SIGNATURE (DATE) *IF BRAND DRUGS ARE PREFERRED, HANDWRITE **"BRAND MEDICALLY NECESSARY"** ABOVE

I authorize the Pharmacy noted above and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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