New Teeth By Pro™

MEDICATION LIST

To provide you with the best dental care, we need to know about your medications and allergies. Please list all medications you take (prescription, over-the-counter, or supplements) or check "No Medications" below.

Instructions:

Write one medication per row. Include the name, reason, dose, and how often you take it.
Example: Lisinopril | High blood pressure | 10 mg | Once daily

Medication	Reason Taken	Dose	How Often?

Medication Allergies:
☐ None ☐ Yes, list:

_____

No Medications: **[ ]** I am not taking any medications or supplements.

Acknowledgment:
I confirm the information above is accurate to the best of my knowledge.

Patient Name: _____

Signature: _____ **Date**: _____