AMERICARE COMPOUNDING

319 Nassau Blvd Garden City, NY 11530 Phone-516-292-5141 Fax-516-292-2201
Compounding@americareps.com

Patient information

Patient name:	
Address:	
City, State, Zip:	
Primary phone:	
Alternate phone:	
Email:	
Primary Language:	
Drug allergies:	
Gender:	
Date of Birth:	

Practice Information

Practice Name:	
Prescriber Name:	
Office Contact:	
Office Contact Email:	
Phone number:	
Fax Number:	
Deliver to Address:	
City, State, Zip:	
Prescriber NPI:	
Today's Date:	

Please attach a copy of front and back of patient's insurance card.

Flavoring available for all compounds–Other flavors available upon request
☐watermelon, ☐strawberry, ☐bubblegum, ☐mint

Orofacial/TMJ Pain Cream	**Amantadine 10%, Diclofenac 5%, Baclofen 2%, Bupivacaine 1%, CyclobenzPentoxifylline 3% Cream** ☐Qty:60gm _____ refills ☐Qty: 120 gm _____ refills Sig: Apply externally two to three times daily as directed
	Diclofenac 3%, Lidocaine 5%, Pentoxifylline 3% Cream ☐Qty:60gm _____ refills ☐Qty: 120gm _____ refills Sig: Apply topically two to three times daily as directed
Herpes Cold Sore Ointment	**Acyclovir 5%, Hydrocortisone 0.05% Lip Balm** ☐Qty: 1 Lip Balm _____ refills Sig: Apply to sore three times daily as directed
Canker Sore Ointment	**Camphor, Phenol, Eugenol Topical Paste** ☐Qty: 30gm _____ refills Sig: Apply to sore three times daily as directed
Angular Chelitis Angular Chelosis	**Formula 1: <u>Clotrimazole</u> 2%, Ibuprofen 2%, Tea Tree Oil 5% Topical Cream** ☐Qty:30gm _____ refills ☐Qty: 60gm _____ refills **Formula 2: <u>Miconazole</u> 2%, Ibuprofen 2%, Tea Tree Oil 1% Topical Cream** ☐Qty:30gm _____ refills ☐Qty: 60gm _____ refills Sig: Apply to affected area three to four times daily as directed
Oral Lichen Planus	**Tretinoin 0.1%, Clobetasol Propionate 0.05% Oral Adhesive Paste** ☐Qty:30gm _____ refills ☐Qty: 60gm _____ refills Sig: Apply to affected area once daily as directed

Original Prescription Required in NYS-Please attach, fax, escribe, call in, or mail to:
Americare Compounding, LLC.