Note: If you do NOT take any medications, please still fill out the top portion. We need the pharmacy you would like us to send your medications needed for the day of surgery.

SAOMSA

San Antonio Oral & Maxillofacial Surgery Associates
***Diplomate of the American Board of Oral & Maxillofacial Surgery**

Medication List 

Patient Name: _____ **D.O.B:** _____

Height: _____ **Weight:** _____ **Preferred Pharmacy:** _____

Pharmacy Phone #: _____ **Pharmacy Address:** _____

Prescribing Doctor/ Specialty/ Phone#: _____

Prescribing Doctor/ Specialty/ Phone#: _____

Prescribing Doctor/ Specialty/ Phone#: _____

Medication Name: _____ **Dosage:** _____ **Reason:** _____

Medication Name: _____ **Dosage:** _____ **Reason:** _____

Medication Name: _____ **Dosage:** _____ **Reason:** _____

Medication Name: _____ **Dosage:** _____ **Reason:** _____

Medication Name: _____ **Dosage:** _____ **Reason:** _____