Medication Log

Patient Name: _____

Date of Birth: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Pharmacy: _____

Pharmacy Phone: _____

Allergies: _____

_____

_____

Surgical History: _____

_____

_____

Implanted Devices: _____

Date	MED/DOSE/FREQU	Reason for taking Medication

Treatment Consent

I hereby consent and give permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary during my course of treatment.

_____ _____

Signature of Patient or Guardian Date