Hamilton Mill
Oral And Facial Surgery

Yadira Cardona-Rohena, DMD

Diplomate of the American Board of Oral and Maxillofacial Surgery
Diplomate of the National Dental Board of Anesthesiology

PAIN MEDICATION AND PRESCRIPTION REFILL POLICY

1. I agree to allow 48 hours for prescription refills.
2. I understand that prescription refills requested after 4:00pm will not be received until the next business day.
3. I understand that a follow-up visit may be required from my physician in order to obtain a refill.
4. I agree to take all medication exactly as instructed. I am **NOT** allowed to change the dosage amounts or alter the time schedule of taking the medication without first speaking to my physician.
5. Narcotics and non-narcotic medications will **NOT** be phoned in after hours or on the weekends.
6. Patients may be terminated from the practice with 30 days notice for noncompliance taking their medications.
7. Hamilton Mill Oral and Facial Surgery will **NOT** refill prescriptions that have been lost of misplaced.
8. I must keep all appointments as recommended.
9. I will not give, trade or sell medications.
10. The following are conditions for immediate termination from the practice.
    1. Obtaining narcotics from any other physician while under ***Hamilton Mill Oral and Facial Surgery's Care.***
    2. Altering or forging a prescription. *This is a felony and will be reported.*
11. I am aware that most of the manufacturers of drugs used to treat chronic pain recommend against the operation of heavy equipment, which includes driving a motor vehicle. Please be aware that if you choose to drive a vehicle you could be charged with a DUI.
12. I will not combine any narcotic medications with the consumption of alcohol.
13. Only one pharmacy may be used to filling prescriptions.

Pharmacy Name: _____ Pharmacy Number: _____

Pharmacy Address: _____

** Please notify us if you change pharmacies**

I have read, understand and agree to the policies above. I understand that if I do not sign this document, my physician may refuse to prescribe me pain medications.

Patient Name: _____

Patient Signature: _____