

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ DOB: \_\_\_\_\_

Credit Card #: \_\_\_\_\_ Exp Date: \_\_\_\_\_

Allergies: \_\_\_\_\_

## Facial Dermatology Creams— "Tonic Youth"

Peptides • Idebenone 1% • Hyaluronic Acid 0.5% • CoQ10 1% • Estradiol 0.01% • Estriol 0.4% Retinoic Acid 0.01%
Peptides • Idebenone 1% • Hyaluronic Acid 0.5% • CoQ10 1% • Retinoic Acid 0.01%
CoQ10 1% • Lipoic Acid 5% • Vitamin C Ester 5%
Lipoic Acid 5% • DMAE 3% • Glycolic Acid 3%
CoQ10 1% • Lipoic Acid 5% • Vit C Ester 0.5% • DMAE 3% • Retinoic Acid 0.025% • HA 5%
CoQ10 1% • Idebenone 1% • Vit C Ester 0.5% • DMAE 3% • Retinoic Acid 0.025% • HA 5%
Retinoic Acid 0.01% • Glycolic Acid 3% • HC 1.25%
Retinoic Acid 0.025% • Vitamin C Ester 5%
Kinetin 0.1% • Idebenone 1%
DMAE 1% • Lipoic Acid 1% (For bags and dark circles around eye)

Sig: \_\_\_\_\_

Refill: 0—1—2—3—6 Months—1 Year

M.D. Signature: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

DEA: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**Ship To:**

- Patient
- Physician Office

**Bill To:**

- Patient
- Physician Office

