Dentistangpinoy.com

Name of Clinic: _____
Address: _____
Contact nos. _____

Name of Patient_____
Address _____Age___
Date _____

Oral Metronidazole 500 mg

#_____ capsules

Sig: Take one (1) capsule every 6-8 hours for 7 days

Dr. _____
Lic # _____

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