Allergy Extract Reorder Form

This form must be completed before vials are mixed

Patient Name: ____DOB: ________________________

Date of last injection (s): ____

Female Patient: Are you pregnant? _______________________________ If yes, please contact our office

List Current medications: ____

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Epinephrine Auto-Injector Expiration Date: ____

Pharmacy Used: ____

Home Address: ____

Telephone Number: _________________________________ ___________________________________

Residence Work or Cell

Current Insurance: ________________________________ I.D. Number: ____________________________

Subscriber's Name: ____

Subscriber's Date of Birth: _______________________

Subscriber's Place of Employment: ____

Is a referral Required from Primary Care Physician? ☐YES or ☐NO

Your Current Primary Care Physician: ____

Are you having any problems with your injections? ____

Name of your ENT & Allergy Specialists Physician: ____

If applicable, would you like the strength of your vial(s) increased? ☐ YES ☐ NO

(If there are changes made to your vials, this could require you to re-advance in our office for 6 weeks)

Dou you feel that your allergy injections are beneficial? ☐ YES or ☐NO If no, please explain:

____

I wish to continue allergy injections. I understand that the allergy extract that I am ordering is prepared especially for me. It cannot be used for any other person. If I choose not to pick up this vial of extract, I realize that I am still financially responsible for it. I, therefore, authorize the office of ENT & Allergy Specialists to bill my insurance for this extract. For Sublingual Immunotherapy, I authorize the office to bill myself for the extract.

Print Name: ____

Signature: ____ Date: ___________________________

You may fax, mail, drop off in the office or email this order form. Email: allergy@nkyent.com

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