ENT & Allergy Specialists

Allergy Extract Reorder Form

This form must be completed before vials are mixed

Patient Name: _____ DOB: _____

Date of last injection/Drop(s): _____

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

List Current medications: _____

_____

Epinephrine Auto-Injector Expiration Date: _____ Not applicable per my physician ☐
(Check box)

Pharmacy Used: _____

Are you having any problems or reactions with your injections? _____

Have your allergy symptoms improved? Yes or No (please explain if no)

☐ **Check Box if No Change with Insurance or Personal Information**

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** (circle one)

Your Current Primary Care Physician: _____

Name of your ENT & Allergy Specialists Physician: _____

I wish to continue allergy injections/sublingual drops. 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 use this vial/bottle 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: _____

Phone: (859) 781-4900 Fax: (859) 572-3036 Email: allergy@nkyent.com

You may fax, email or hand deliver this order form to our office
If the allergy department does not contact you within 1-2 weeks from the date this form is returned to our office, please inquire to see if your extract is ready.