ALLERGY VIAL(S) RE-ORDER FORM

NAME_____ DATE REQUESTED_____
ADDRESS_____

_____
CITY STATE ZIP CODE

PLEASE CHECK APPROPRIATE BOXES BELOW
SHOTS ☐ SUBLINGUAL ☐

PLEASE CHECK APPROPRIATE BOXES BELOW
BURLINGTON OFFICE PICK-UP ☐ MEBANE OFFICE PICK-UP ☐

MAINTENANCE (CONC) VIAL #1 ☐ VIAL #2☐ VIAL#3 ☐
NON MAINTENANCE (ANTIGEN NUMBER) VIAL #1☐ VIAL#2 ☐ VIAL #3 ☐

NO PHONE ORDERS ACCEPTED
MAIL/EMAIL FOR INHALANT VIALS 2 WEEKS BEFORE NEW VIAL NEEDED
MAIL/EMAIL FOR FOOD VIALS WHEN YOU RECEIVE 16TH INJECTION

THE FOLLOWING INFORMATION MUST BE COMPLETED IN ORDER TO RECEIVE YOUR VIAL

Current Insurance Company:_____
Claims Address:_____
Policy #:_____
Group #:_____
Effective Date:_____

Please update this vial card:
*You are responsible for providing our office with your insurance and any authorizations that may be required.