THE WILLIAM STORMS ALLERGY CLINIC

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900 Indiana Ave, Ste C
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Tel: 1-866-615-3885
Pollen report: 719.955.1933

www.stormspollen.com

EXTRACT REORDER

Your allergy extracts need to be reordered. Please complete this form (or have the shot facility do it for you) sign and date below to authorize us to prepare new extract for you. By signing, you agree to be responsible for any charges not covered by insurance. Extracts are prepared and billed in a three or six month supply, depending on your insurance. If the patient is less than 18 years old, a parent or guardian must sign.

HMO patients: We need a copy of your current referral in order to prepare the antigen.
Please fax a current copy of your insurance card with this form.

If you have any questions please call our office. Please fax or mail this form to our office two weeks prior to expiration to allow time to process and mail extracts.

Patient

Name: ________________________________

Address: ______________________________

City/State/Zip: __________________________

Phone: ________________________________

Current Insurance: _______________________

IT Location (where you get your shots)

Doctor or Clinic: ______________________

Address: _____________________________

City/State/Zip: ________________________

Phone: ______________________________

Extract (Trees, grass, etc) ______________ Date of last injection: ___________ Dose: __________ Dilution: (1/20 etc) _______________

Extract (Trees, grass, etc) ______________ Date of last injection: ___________ Dose: __________ Dilution: (1/20 etc) _______________

Extract (Trees, grass, etc) ______________ Date of last injection: ___________ Dose: __________ Dilution: (1/20 etc) _______________

______________________________________ ____________________

Patient's SIGNATURE or Parent/Guardian signature (If patient is under 18) *Date Signed*