Joseph Pflanzer, M.D.
Diplomate of the American Board
of Allergy and Immunology

Allergy & Clinical Immunology

2801 Bolton Boone, Suite 101
DeSoto, Tx 75115
(972) 298-6677
Fax (972) 298-5583
allergicclinic@yahoo.com

Extract Re-Order Form

Patient Name _____ Account #_____

WhatVial # are you ordering? _____
Have you had any reactions to you last vial? **Yes/ No** (Please Circle One)
If You circled " Yes" then please describe reaction:_____
_____
_____

Amount Due is an approximate amount based on Insurance Benefits we have in our system at the time the extract was ordered. Please provide any new insurance information if necessary. Any discrepancies in the Insurance payments must be directed to your insurance company.

Order Information: ******PLEASE CHECK THE BOX FOR EACH ITEM THAT YOU ARE ORDERING. EXTRACT OR SYRINGES WILL NOT BE MAILED UNLESS INDICATED.**

( )Extract (pt amt. : _____
( ) Syringes + **:** $5.00 for each pack___
( ) Mailing fee + : $6.00 serum only
( ) Mailing fee + : $12.00 serum and syringes (not including price of syringes)

We are no longer able to accept phone in orders. Please send in this form if you would like to reorder serum. Thank You

Total Amount Due: _____

Please mail, fax, email, or bring this form to the office four (4) injection prior to the end of your Allergy serum. Please allow at least 7-10 business days to pick up your new vial of Allergy Extract. Thank You.

Payment Options
( ) Check Enclosed Amount Paid $_____
( ) Credit Card
Card#_____
Expiration Date:_____ CVC_____
Type of card_____
Signature_____

Additional Information: