ALLERGY AND ASTHMA CENTER OF HILTON HEAD
Thomas C. Beller, MD
60 Main Street, Suite D
Hilton Head Island, SC 29926
Phone: 843-689-6442 Fax: 888-397-1781
Email: **refills@hiltonheadallergy.com**

EXTRACT REORDER FORM

To request a refill on your allergy extract, complete the following information and mail/fax it to the office not less than 2 weeks in advance of the date the extract will be required. For your safety, telephone orders will not be accepted.

Patient's Full (Legal) Name: _____
Account Number: _____ Phone Number: _____

I will PICK-UP extract in: HH ____ Bft ____ NR ____ Please MAIL/SEND extract _____

****PAYMENT is expected prior to mailing/sending your extract. For your convenience, we accept personal checks, MasterCard and Visa. Please include a $9.00 shipping and handling fee with your payment.****

Mail To: Name: _____

Address: _____

City, State, Zip: _____

Visa/MasterCard #: _____ CRV: _____ Exp. Date: _____
PRINT NAME as it appears on the card: _____

I authorize the refill of my (child's) allergy extract. I understand and agree to pay for the refill/s when billed by the Allergy & Asthma Center of Hilton Head.

_____ _____
Signature (Patient/Parent) (Date)

SHOT RECORDS MUST ACCOMPANY THIS FORM!!!

We will not be able to complete this order without this form and current injection schedules.

Expiration Date of epinephrine autoinjector: _____

Current medications: _____
_____
_____

TCB/ljsn
05/17