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Adult and Pediatric Diseases of the Ear, Nose, and Throat * Head & Neck Surgery Allergy Testing and Treatment*
Hearing and Balance Disorders

# Sublingual Drops (SLIT) Reorder Form

**PLEASE ALLOW 7 DAYS FOR PREPARATION OF MIX**

Order Date: _____ Physician_____

Patient's Name: _____ DATE OF BIRTH : _____

Phone number_____ EMAIL: _____

Address if mailing:_____

Pick up location (CHOOSE ONE) : Hermitage_____ Lebanon _____

Any reactions to the drops? _____

Do you take blood pressure medication? Yes : _____ No: _____

If YES, name of medication? _____

Are you taking a daily antihistamine? Yes : _____ No: _____

Do you have a current eip-pen? Yes : _____ No: _____

**Drops must be paid for PRIOR to mix being made.**

Name on Credit Card exactly as printed : _____

Billing Address for Credit card including Apt #, City, State, and Zip:

_____

Credit Card # _____ Exp Date : _ _ / _ _ _ _ CVV Code: _____

Total amount to be charged (including shipping and handling **$11.50**) : _____

Signature : _____ Today's Date : _____

Would you like your card saved on file for orders: YES _____ NO _____

Would you like to register for auto reorder: YES: _____ No: _____ ***If yes fill out AUTO reorder sheet and attach**

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