Kevin Lunde, M.D.
4701 Plano Parkway Suite 150
Plano, TX. 75093
972-985-3223
Fax 972-964-0562
tina@kevinlundemd.com

Please complete this entire form before ordering a new vial. Mail, fax, email or bring this form to our office. PLEASE ALLOW 2 WEEKS FOR MORE VACCINE.

HOME REPORT FOR SUBLINGUAL DROPS

Name: ____

Address: ______________________________________

City: ____________________________Zip Code______________

Daytime Phone Number: __________________________

Email Address: _________________________________

Please describe any reactions that you had to the drops including the date of the last administration of drops and the date of the reaction.

- Need more allergy vaccine. PLEASE ALLOW 2 WEEKS FOR MORE VACCINE.
- Please be advised that if your insurance changes and requires a referral or authorization to receive allergy vaccine, you will be responsible for all charges for services received between the effective date of your new insurance and the effective date of your authorization.
- Please provide the following if your insurance has changed:
- Insurance company: ______________________________________
- Phone number: ____
- Address: ____
- Policy Holders Name: _____________________________________
- Group #__________ ID#__________ Date of Birth_____________

Please check one of the following:

- Vaccine will be picked up at the office
- Mail vaccine to above address