

**Eastern Carolina ENT Associates, PA
(919) 934-0948**

Name: _____

Address: _____

DOB: _____

Please complete the following information and return to our office for your allergy vial refill. Please allow 2 weeks for delivery.

DATE _____

MAILING
ADDRESS _____
(IF DIFFERENT FROM ABOVE)

PLEASE MAIL MY _____ VACCINE

LAST DOSE
DATE: _____ AMOUNT _____ CC.

**Complete this form and mail to:
EASTERN CAROLINA EAR, NOSE AND THROAT
P.O. BOX 571
SMITHFIELD, NC 27577**