Allergy and Asthma Associates, P.C.

Sharon Seth, MD Courtney J. Blair, MD Bridget Schaefer, PA-C

PATIENT REQUEST FORM

Patient name: _____ Date of Birth:_____/_____/_____ Weight: _____lbs

Requested by: _____ Relation: _____

Please circle: Has the patient had any anaphylaxis? **YES / NO** Self-carry Epinephrine? **YES/NO**

Self-Administer Epinephrine? **YES/NO**

TYPE OF REQUEST

◯ School Form (provide form) ◯ Disability Form (provide form)

◯ Letter From Provider (please explain) _____

◯ Other (please explain) _____

PLEASE SEE RECEPTION FOR ANY FEES ASSOCIATED WITH YOUR REQUEST. PAYMENT MUST BE MADE PRIOR TO REQUEST BEING PROCESSED AND ACCOUNTS MUST BE CURRENT. SOME REQUESTS MAY REQUIRE AN OFFICE VISIT.

ONCE REQUEST IS PROCESSED, PLEASE NOTIFY ME BY:

◯ Email: _____ ◯ Text:_____

ONCE NOTIFIED, I WOULD LIKE MY REQUEST:

◯ Faxed to: _____

◯ Mailed to (MUST provide address): _____

◯ Left in office for pick up (select one): ◯ STERLING OFFICE ◯ MCLEAN OFFICE

I UNDERSTAND I AM GIVING MY CONSENT FOR CONFIDENTIAL INFORMATION TO BE DISCLOSED.
I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING TO THE PERSON IN POSSESSION OF MY RECORDS.

_____ _____/_____/_____

SIGNATURE **DATE**

OFFICE USE ONLY

46400 Benedict Dr. Ste.003 Sterling, VA 20164 (703)430-0833 Fax (703)430-6073
1360 Beverly Rd. Ste.103 McLean, VA 22101 (703)356-8290 Fax (703)356-8031

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DATE: _____/_____/_____ **INITIALS**:_____ **PAYMENT TYPE**: : □ COF □ CASH □ CHECK □ CC □ OTHER

AMOUNT COLLECTED : $_____ **PATIENT CASE CREATED**: _____

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