

Vaccination Clinic Registration Form

	Patient Legal Last Name	Patient Legal First	: Name	Middle Initi	ial(s) Suffix: Jr Sr I II III
	Date of Birth / /	Sex: Male Female		Social Security Number — For Patient Identification	
	Primary Phone No.: Type:	e: Cell Phone Work		Marital Status:	
Patient Information			☐ Divorced ☐ Legally Separated		
	Secondary Phone No.: Type:			☐ Life Partner ☐ Married ☐ Widow/Widower	
				☐ Never M	☐ Never Married ☐ Widow/Widower
	Street (Home) Address	City	State	Zip	Race:
Pati	Mailing Address	City	State	Zip	Ethnicity: Hispanic/Latino Not Hispanic
					☐ Unknown/Refused
	Employment Status: Disabled Retired Unemployed Full Time Part Time Active Military				
	If Employed, Employer Name and Address: Emplo				Employer Phone No.:
	☐ I Do NOT Have Healt	h Insurance			
		:h Insurance Subscriber Number			I provided this Insurance card today: Yes No
	Primary Insurance S			nt □ Other	card today: ☐ Yes ☐ No
	Primary Insurance S Relationship to Subscriber: Complete Subscri	Subscriber Number Self Spouse Seler name & Date of	☐ Pare		card today: Yes No : er is NOT the patient
u	Primary Insurance S Relationship to Subscriber:	Subscriber Number ☐ Self ☐ Spouse	☐ Pare		card today: Yes No
ormation	Primary Insurance Relationship to Subscriber: Complete Subscri Subscriber Last Name:	Subscriber Number Self Spouse Seler name & Date of	☐ Pare f birth below t Name:		card today: Yes No : er is NOT the patient
ce Information	Primary Insurance Relationship to Subscriber: Complete Subscri Subscriber Last Name: Secondary Insurance Relationship to Subscriber:	Self Spouse Subscriber Number Subscriber Firs Subscriber Number Self Spouse	☐ Pare f birth below t Name: r ☐ Pare	w, if Subscribe	card today: Yes No : er is NOT the patient Subscriber Date of Birth: I provided this Insurance card today: Yes No
surance Information	Primary Insurance Relationship to Subscriber: Complete Subscri Subscriber Last Name: Secondary Insurance Relationship to Subscriber:	Self Spouse Subscriber Number Subscriber Firs Subscriber Number Self Spouse	☐ Pare f birth below t Name: r ☐ Pare f birth below	w, if Subscribe	card today: Yes No : er is NOT the patient Subscriber Date of Birth: I provided this Insurance card today: Yes No :
Insurance Information	Primary Insurance Relationship to Subscriber: Complete Subscri Subscriber Last Name: Secondary Insurance Relationship to Subscriber: Complete Subscri Subscriber Last Name:	Self Spouse Subscriber Number Subscriber Firs Subscriber Number Self Spouse Subscriber Number Subscriber Number	☐ Pare f birth below t Name: Pare f birth below t Name:	w, if Subscribe	card today: Yes No : er is NOT the patient Subscriber Date of Birth: I provided this Insurance card today: Yes No : er is NOT the patient
Insurance Information	Primary Insurance Relationship to Subscriber: Complete Subscri Subscriber Last Name: Secondary Insurance Relationship to Subscriber: Complete Subscri Subscriber Last Name: Tertiary Insurance Secondary Insurance Relationship to Subscriber: Complete Subscriber: Complete Subscriber: Complete Subscriber: Complete Subscriber:	Self Spouse Subscriber Number Subscriber Firs Subscriber Number Subscriber Number Subscriber Firs Subscriber Number Subscriber Number Subscriber Number	☐ Pare f birth below t Name: Pare f birth below t Name:	nt Other w, if Subscribe	card today: Yes No card today: Yes No card today: Yes No Subscriber Date of Birth: I provided this Insurance card today: Yes No card today: Yes No i provided this Insurance card today: Yes No I provided this Insurance card today: Yes No i
Insurance Information	Primary Insurance Relationship to Subscriber: Complete Subscri Subscriber Last Name: Secondary Insurance Relationship to Subscriber: Complete Subscri Subscriber Last Name: Tertiary Insurance Secondary Insurance Relationship to Subscriber: Complete Subscriber: Complete Subscriber: Complete Subscriber: Complete Subscriber:	Self Spouse Subscriber Number Subscriber Firs Subscriber Number Subscriber Number Subscriber Firs Subscriber Number Subscriber Number Subscriber Number	☐ Pare f birth below t Name: Pare f birth below t Name: Pare f birth below	nt Other w, if Subscribe	card today: Yes No card today: Yes No card today: Yes No Subscriber Date of Birth: I provided this Insurance card today: Yes No card today: Yes No I provided this Insurance card today: Yes No

Submit this completed form to the registrar after you have received your vaccine.