Hilo Medical Center

Vaccination Clinic Registration Form

Patient Information

Patient Legal Last Name	**Patient Legal First Name**	**Middle Initial(s)**	**Suffix:** ☐ Jr ☐ Sr ☐ I ☐ II ☐ III
Date of Birth / /	**Sex:** ☐ Male ☐ Female	**Social Security Number –** For Patient Identification - -	
Primary Phone No.: **Type:** ☐ Cell ☐ Phone ☐ Work		**Marital Status:** ☐ Divorced ☐ Life Partner ☐ Never Married ☐ Legally Separated ☐ Married ☐ Widow/Widower	
Secondary Phone No.: **Type:** ☐ Cell ☐ Phone ☐ Work			

Street (Home) Address	**City**	**State**	**Zip**	**Race:**
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:				Employer Phone No.:

Insurance Information

☐ **I Do NOT Have Health Insurance**

Primary Insurance	**Subscriber Number**	I provided this Insurance card today: ☐ Yes ☐ No
Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Other:		
Complete Subscriber name & Date of birth below, if Subscriber is NOT the patient		
Subscriber Last Name:	Subscriber First Name:	Subscriber Date of Birth:
Secondary Insurance	**Subscriber Number**	I provided this Insurance card today: ☐ Yes ☐ No
Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Other:		
Complete Subscriber name & Date of birth below, if Subscriber is NOT the patient		
Subscriber Last Name:	Subscriber First Name:	Subscriber Date of Birth:
Tertiary Insurance	**Subscriber Number**	I provided this Insurance card today: ☐ Yes ☐ No
Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Other:		
Complete Subscriber name & Date of birth below, if Subscriber is NOT the patient		
Subscriber Last Name:	Subscriber First Name:	Subscriber Date of Birth:

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