

Vaccination Clinic Registration Form

For Internal Use:
 Patient Name:
 Account Number:
 Medical Record #:

Patient Information	Patient Legal Last Name		Patient Legal First Name		Middle Initial(s)	Suffix: <input type="checkbox"/> Jr <input type="checkbox"/> Sr <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III	
	Date of Birth / /		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security Number – For Patient Identification - -		
	Primary Phone No.: Type: <input type="checkbox"/> Cell <input type="checkbox"/> Phone <input type="checkbox"/> Work		Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Life Partner <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widow/Widower				
	Secondary Phone No.: Type: <input type="checkbox"/> Cell <input type="checkbox"/> Phone <input type="checkbox"/> Work						
	Street (Home) Address		City	State	Zip	Race:	
	Mailing Address		City	State	Zip	Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Unknown/Refused	
	Employment Status: <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Active Military						
	If Employed, Employer Name and Address:					Employer Phone No.:	

Insurance Information	<input type="checkbox"/> I Do NOT Have Health Insurance					
	Primary Insurance		Subscriber Number		I provided this Insurance card today: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> 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.