

Influenza Vaccine Registration Form 2020

Name: _____ Date of Birth: _____

SSN _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

E-mail Address _____

Male / Female _____ Race _____ Marital Status _____

Employer _____

Occupation _____ Work Phone _____

❖ Please attach a copy of insurance card (front & back)

❖ If you are **not** the insured, please provide their Name, DOB, SSN & relationship to you below:

Name: _____ Date of birth _____

SSN _____ Relationship to you _____

We will file your insurance as a courtesy to you, however, you are responsible for the bill if your insurance carrier applies the charges towards your deductible, denies services, or considers the services non-covered. By signing below, you are giving us consent to file your insurance carrier for the vaccine rendered.

Signature _____

Date _____