Registration Form

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 _____

Emergency Contact _____

Phone _____ Relationship to you _____

- Please attach a copy of insurance card (front & back)
- If you are not the insured, please provider 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 _____