COVID
Vaccine Clinic
Registration

Wood River Health Services

The Heart of South County Since 1976

Last _____ **First** _____ **MI** ___ **Preferred Name**_____

Birth Date ___/___/___ **Gender at birth** ☐ Female ☐ Male

Street Address:_____**City/State/Zip:**_____

Mailing Address (if different)**:** _____**City/State/Zip:** _____

Phone number: ***Please check box to select the number that you would like us to call first.***

☐**Home** ( ) _____ ☐**Cell** ( ) _____

Email Address: _____

INSURANCE INFORMATION

Primary Medical Insurance:

Type	Insurance Company Name	Policy #	Insured Name (if different than patient)	DOB
MEDICAL Ins #1				
MEDICAL Ins #2				

EMERGENCY CONTACT

Name: _____ Phone ( ) _____ Relationship: _____

CONSENT FOR TREATMENT

I give my consent to Wood River Health Services to provide treatment for myself, or the named patient (of whom I am the parent or guardian).

I allow Wood River Health Services to file for insurance benefits to pay for the care I receive.

I understand that:

- **Administration of the vaccine will be billed to my insurance company**; only the vaccine itself is free
- **Administration of the vaccine for uninsured patients will be billed to the COVID Uninsured Program under the CARES Act**

I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.

_____	___/___/___	_____
Patient Name (Please print)	**Date of Birth**	**Patient (or Guardian) Signature**