

Alan's Covid Vaccination Patient Intake Form and Patient's Authorization
PHARMACY

Section 1 Patient Information

First Name: _____ Last Name: _____ Middle: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

DOB: _____ Age: _____ Gender: _____

State that you were Born: _____

Ethnicity: White/Caucasian Hispanic/Latino Black/African American Asian
 Other Please Specify: _____

Section 2 Insurance Information

Insurance Company: _____

Social Security Number: _____

Cardholder: _____ Relationship: _____

Section 3: Administration Information

Lot #: _____ Exp: _____ Pharmacist: _____

Section 4: Patient's Copy

Vaccine Date: _____ Vaccine Time: _____ Dismissal Time: _____

Return Date: _____

Scheduled for appointment Reminder _____ Yes _____ No

1721 W 6th Ave
Stillwater, OK 74074
405-372-3331

Return to:

Alan's
PHARMACY