Covid Vaccination Patient Intake Form and Patient's Authorization

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:___________________________ BIN Number:_________________ PCN:_______________

Member ID:___________________________ Group 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

Return to:

1518 W 9th Ave
Stillwater, OK 74074
405-377-4445