Patient COVID Vaccine Registration Form

MRN _____ **Date:** _____

Do you have any COVID symptoms: ___ Yes ____ NO when did the symptoms start: _____

Patient Name: _____
(Last Name) (First Name) (Middle Initial)

Date of Birth: ___/___/___ **Social Security/ W7:** _____-_____-_____
Occupation: **_____

Mailing Address Information

Address _____

City _____ State _____ Zip _____

Phone Number _____ (Please Select: Work/Cell/Home)

Email: _____

Emergency Contact: _____**Phone #:** _____
Relationship: _____ **Legal Guardian DOB: _____**

Sex: □Male □Female □Transgender (Male to female) □ Transgender (Female to Male)

Sexual Orientation: □ Straight (not lesbian or Gay) □Lesbian or Gay □ Bisexual □ something else □ don't know □ Choose not to disclose

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed
Employed: □ Full time □ Part time □ Unemployed □ Student Full time □ Student Part Time □ Retired

Race (Please select all that apply)
□ White/Caucasian □ Black/African American □ American Indian □ Asian
□ Native Hawaiian □ Other Pacific Islander □ Alaskan Native □ Other: _____

Are you of Hispanic or Latino origin? □ Yes □ No
Country of Origen? _____
Are you a Veteran of one of the U.S. Armed Forces? □ Yes □ No
Are you covered under BCBS, UHC, AETNA, Cigna, Medicaid, Medicare, Bright Health or any other Health Insurance? □ Yes □ No if the answer is **Yes** please enter the name of the insurances and ID number:
_____

Do you need a Medical Provider? □ Yes □ No
How do you hear about us: _____