ADULT FLU VACCINE REGISTRATION

NAME: (Last, First, Middle Initial) _____

BIRTHDATE: _____ SSN# _____

ADDRESS: _____

_____

HOME PHONE: _____ CELL PHONE: _____

PRIMARY CARE PHYSICIAN: _____

PRIMARY INSURANCE INFORMATION:

NAME OF COMPANY: _____

NAME OF INSURED: _____ BIRTHDATE: _____

POLICY # _____ GROUP # _____

EFFECTIVE DATE OF POLICY: _____

INS. CO. ADDRESS _____

_____

We will bill your insurance company for your vaccination. We cannot guarantee payment. If the insurance company does not pay for the vaccine and the administration of the vaccine you will be responsible for the charges.