Flu Vaccine Demographic Form

Please complete, print and bring this form to your flu vaccine appointment.

Last Name: First Name:

Male: Female:

Date of Birth: Age: Phone:

Address: Apt #:

City: State: Zip:

Email: SSN (last 4 #s) Insured: YES NO

Insurance Carrier:

Member ID#:

Policy Holder: Self Other

If Other, Specify Name: Date of Birth:

Immunocompromised or over the age of 65? YES NO

(Nursing documentation only)

High Dose Routine Dose

****Reminder - Bring your ID and insurance card to your appointment****