

Southeast Community Health Systems COVID-19 Vaccination Form

Health Systems	Date:
NAME:	Age Male Female Race
ADDRESS:	D.O.B/
City:	PHONE:
State: Zip:	Language:
Have you tested positive for COVID-19 in the past 90	
Have you ever had a reaction to vaccines or any comp	
Immunization given in: Right Left	deltoid Administer Initials:
INSURANCE INFORMATION A Copy of the Patient's Insurance Card and Driver's License can be used in place of the data below.	
PLAN # 1 Information	
Insurance Company:	
Member ID #:	Group #: Patient's
Relation to Subscriber: Self Child Parent Self Child Parent Self Self Child Parent Self Se	Spouse Employer Other
	complete the rest of this section)**********
First Name: Middle Name: Suffix: Social Security Number:	
Date of birth (mm/dd/yyyy):	Cender: a Marc a remarc
	City: State:
Street Address: Zip: Home Phone:	Mobile/Cell Phone:
INSURANCE CONSENT I authorize Southeast Community Health Systems (SCHS) or its agents to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested services. I assign and request payment of authorized benefits be made on my behalf to SCHS or its agents with respect to the requested services.	
Signature of Patient or Authorized Representative _	Date: