Southeast Community Health Systems COVID-19 Vaccination Form

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 days? YES ____ NO _____

Have you ever had a reaction to vaccines or any component of a vaccine? YES _____ NO _____

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 □ Spouse □ Employer □ Other_____
**********If Patient is Subscriber (No need to complete the rest of this section)**********
First Name:_____ Middle Name:_____ Last Name:_____
Suffix:_____ Social Security Number:_____ Gender: □ Male □ Female
Date of birth (mm/dd/yyyy): _____
Street Address:_____ City:_____ State:_____
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: _____