LOWELL GENERAL HOSPITAL

COVID19 VACCINATION CLINIC (PAID BY PATIENT INSURANCE PLAN)

Location: ______________________ **Date:** _____________ **Time:** ______________

Please complete the following information (please PRINT):

Name: ____
First MI Last

DOB: _____/_____/_____ Gender: ___________________

……………………………………………………………………………………………

Social Security #: ___________________ **PCP:** _____________________________

Marital Status: _____ **Race:** _____________ **Ethnicity:** ________________

Nationality: ______________ **Language:** _____________

Mailing Address: ____
(Street, City, State, Zip)

Telephone: ____________________

Health Insurance: (complete section below *and* hand card and license to staff)

Insurance Co Name: ____

ID #: ________________________________**Group #:** ___________________

Policy Holder: _______________________________ **Relationship** ________________

FOR CLINIC USE ONLY

Manufacturer. **Lot:** __________ **Expiration:** _________

Injection Site: ☐ Left Deltoid ☐ Right Deltoid

Signature: ________________________________ **Date:**____________

Clinical Staff:****Please copy both **front and back** of patient's insurance card and license/picture ID if available if copy machine is available