



COVID-19 Vaccine Intake Form

Please Fax or Hand Carry a completed form to:

302 N First Street Silverton, OR 97381 Phone 503-873-6321 Fax 503-874-9811

Demographics

Date: _____ Patient Name: _____
FIRST NAME LAST NAME

Date of Birth: ____/____/____

Address: _____
STREET CITY STATE ZIP

Cell Phone: _____ Home Phone: _____

Occupation : _____ Patient Contact: Yes No

Patient Information Gender: Male Female Other

Race: African American American Indian/Alaskan Native Asian

Native Hawaiian/Pacific Islander White Decline Answer

Primary Language: _____ Ethnicity: Hispanic? Yes No Decline

Drug Allergies: _____

Allergic to Polyethylene Glycol, PEG, COLON PREP? _____

Health Conditions: _____

Would you like easy open caps on your medications? _____ Are generics okay? _____

Do you have INSURANCE with prescription coverage? _____ (if yes please present insurance card)

Have you been offered the Privacy Policy (HIPAA) ? _____

Please attach copies (front and back) of your Insurance card(s) and Medicare card (if you have one.)

- Insurance cards must show RxBIN, PCN, ID#, Rx Group #
- Medicare Card(A and B) – Red, White, and Blue card with randomized alpha-numeric ID #