PEDIATRICS of Northeastern Pennsylvania

COVID VACCINE REGISTRATION FORM

EMAIL FORM TO: OFFICE@PEDSOFNEPA.COM UPON COMPLETION

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name: First:	Middle: [Initial]	Marital status:

Race	**Ethnicity**	Address:	Birth date:	Age:	Sex:
☐ American Indian or Alask Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ All other races ☐ Unknown	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown				◯ M ◯ F

HOW WOULD YOU LIKE TO BE NOTFIED OF YOUR APPOINTMENT: EMAIL, PRIMARY PHONE, BOTH:

SS # or License # if not insured. (this is a Federal requirement)	Email Address:	Primary phone no.:	Secondary phone no.:
Occupation: [Occupation]		Employer:	Employer phone no.:

Established patient name:

Your relationship to the patient:

INSURANCE INFORMATION

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance: Other: [Other insurance- secondary is applicable]

Subscriber's name:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Policy no.:	

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____