MID COAST HOSPITAL

# COVID-19 VACCINE REGISTRATION FORM

For current clinic hours, please visit **www.midcoasthealth.com/vaccine/**

## PERSONAL INFORMATION

**Last Name:** _____ **First Name:** _____ **Middle Initial:** ___

**Date of Birth:** _____ **Age:**_____ **Gender:** _____ **Phone:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip Code**: _____

**Primary Care Physician:** _____

**Race:**
- ☐ American Indian
- ☐ Asian
- ☐ Native Hawaiian/Pacific Islander
- ☐ Black/African American
- ☐ White
- ☐ Other Race

**Ethnicity:**
- ☐ Hispanic
- ☐ Not Hispanic

**Last 4 digits of Social Security Number:** _____

## HEALTH INSURANCE INFORMATION

Primary:_____

Group Number:_____

ID/Certificate Number:_____

Subscriber:_____

Subscriber Date of Birth:_____

Relationship to Patient:_____

Secondary:_____

Group Number: _____

ID/Certificate Number: _____

Subscriber:_____

Subscriber Date of Birth: _____

Relationship to Patient: _____

☐ No Insurance