



Name: _____		
First	Middle Initial	Last
Date of Birth: _____		

Date: _____

Time: _____

Sex: M F

Marital Status: Married Single Divorced Widowed

Mailing Address: _____

Town/City

State

Zip Code

Phone Number: (____) _____ E-mail: _____

Person to notify in case of an emergency:

Name

Relationship

Phone Number

Address if different from above

Insurance Information

Insurance Name: _____

Address: _____

Phone Number: _____

Policy # _____ Group # _____

Subscriber: _____ Relationship to Patient: _____

Primary Care Provider: _____

Authorization for Assignment of Benefits to SMH:

[] \$45.00 Flu Vaccine Flulaval + Administration Fee

[] \$80.00 Flu Vaccine Fluzone- High Dose + Administration Fee

Patient Signature: _____ Date: _____

SMH Representative: _____ Date: _____