SPEARE Memorial Hospital
A Critical Access Hospital

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:_____