COVID-19 Vaccine Intake Form

Please Fax or Hand Carry a completed form to:

910 NW Kings Blvd. Corvallis, OR 97330 Phone 541-752-7779 Fax 541-752-8659

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 #**