Grapevine Drug RX

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COVID VACCINE INTAKE CONSENT FORM

PATIENT & INSURANCE INFORMATION

Full Name: _____ Date of Birth: _____ Gender: ☐ M / F

Last *First*

Address: _____

Street Address *Apartment/Unit #*

_____

City *State* *ZIP Code*

Phone: _____ Email _____

Mother's Name (*first & maiden*): _____ Social Security Number.: _____ DL# / State of Issuance: _____

Primary Care Provider (*Name/ City, State/ Phone number*): _____

Patient Race (*select one*)

- American Indian or Alaska Native ☐
- Asian ☐
- Native Hawaiian/Other Pacific Islander ☐
- Black or African American ☐
- White ☐
- Other ☐

Patient Ethnicity *(select one)*:

- Hispanic ☐
- Not Hispanic or Latino ☐
- Unknown ☐

PRESCRIPTION INSURANCE

Are you the primary cardholder?: YES ☐ NO ☐

If no, name & date of birth of primary cardholder _____

Prescription Benefit Plan Name: _____

Plan Information: _____

Cardholder ID# *Rx BIN* *PCN* *Group*

Medicare Part B Number (if applicable): _____

If uninsured, you must check the box below to attest that the following information is true and accurate:

I do not have any insurance, including but not limited to Medicare, Medicaid, or any other private or government-funded health benefit plan. ☐

In order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for Uninsured Patients, you must provide either (a) a valid Social Security number, (b) state identification number and state of issuance, OR (c) a driver's license number and the state of issuance.

SIGNATURE

I certify that my answers are true and complete to the best of my knowledge.

Signature: _____ Date: _____

Prtinted Name (*of person filing out form*): _____ Relationship: _____