LMHS COVID VACCINE REGISTRATION INFORMATION

Date:_____ Time:_____

Patient Information		
Patient Name (Last Name, First Name, Middle Initial)	Date of Birth	
Social Security # (REQUIRED)	Email Address	
Home Address	City / State / County / Zip Code	Race / Ethnicity / Sex
Phone # with area code	Marital status	
Employer Name		
Occupation / Status		

Emergency Contacts	
Person to Notify / Relationship to Patient	Person to Notify / Relationship to Patient

Guarantor Information ☐ Check box and do not complete if same as above / self		
Guarantor Name	Date of Birth	Social Security #
Guarantor Address	City / State / Zip Code	Relationship to Patient
Guarantor Employer	Employer's Address	Employer Phone #

Insurance Information ☐ Check box and do not complete if insurance card is provided		
Name of Insurance Company	Claims Mailing Address	Insurance Phone #
Policy # / ID#	Group #	Insured's Name
Insured's Employer	Insured's Date of Birth	Insured's SS#

Please place patient label here

Licking Memorial Health Professionals

Registration Information Covid Vaccine

7465-0019
3/4/21, 3/5/21