PART 1: COVID-19 VACCINE INTAKE FORM

heights pediatrics

THIS FORM MUST BE COMPLETED & RETURNED BY 8AM TOMORROW
LATE SUBMISSIONS WILL BE PLACED ON A WAITLIST

VACCINE RECIPIENT - ALL FIELDS REQUIRED

Recipient Name: _____ **Date of Birth:** _____ **Gender:** ☐ Female ☐ Male

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American
☐ Hawaiian Native/Pacific Islander ☐ White

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Address: _____ **Apt #:** _____ **City:** _____ **State:** _____ **ZIP:** _____

Cell Phone Number: _____ **Email Address:** _____

Emergency Contact: _____ _____ _____
contact name **phone number** **relationship to patient**

INSURANCE

***** PLEASE FILL OUT & ALSO SEND COPIES/PHOTOS OF YOUR INSURANCE CARD *****

Insurance Provider: _____ **Member ID:** _____ **Group #:** _____

Are you the policy subscriber? ☐ Yes ☐ No → **If no, please provide:** _____ _____ _____
subscriber name **DOB** **relationship to patient**

***** If you do not have ACTIVE health insurance, please check this box AND write your SSN or State ID/Driver's License # in order for the government to reimburse Heights Pediatrics for your vaccine:**

☐ I currently do not have health insurance. SSN / State ID / Driver's License #: _____

VACCINE INFORMATION

Have you received a previous dose of the COVID-19 vaccine? ☐ Moderna ☐ Pfizer Date (if applicable): _____

MANDATORY NEW YORK STATE COVID-19 VACCINE FORM

Link to form here: vaccineform.health.ny.gov

Please present screenshot of submission or write submission ID: _____

If you have not completed this form, we cannot administer your vaccine. It takes about 2 minutes and can be done on your mobile phone. Thank you!

Signature of Vaccine Recipient or Parent (if under 18): _____

Print Parent Name (if under 18): _____ **Date of Service (your appointment):** _____