



PART 1: COVID-19 VACCINE INTAKE FORM

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:** _____ **Birth Sex:** Female Male

Race: American Indian/Alaskan Native Asian Black/African American
 Hawaiian Native/Pacific Islander White (mark all that apply)

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 Other Date: _____

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): _____