



# Seasonal Flu and Pneumonia Vaccination

## 2011 - 2012 Insurance Information Form

Information about the person to receive vaccine (please print): \*Required Fields

Name: (Last, First, MI)*		Date of birth: * ____/____/____ Month Day Year		Age*	Sex: (Circle)* Male Female
Street Address:*					
City:*	State: *	Zip:*	Phone: * ( )		

**Insurance Information:** Include the whole member ID number and any letters that are part of that number

Name of Insurance Company:*	Member ID Number:*	Group ID Number: (if available)
Name of Secondary Insurance Company:	Member ID Number:	Group ID Number: (if available)

**If person getting vaccinated is not the subscriber, please complete the following:**

Subscriber's Name: (Last, First, MI)*		Subscriber's Date of Birth: * ____/____/____ Month Day Year		Sex: (Circle)* Male Female
Subscriber's Street Address: * (If different from address above)				
City:*	State:*	Zip: *	Phone: * ( )	
Patient Relationship to Subscriber: (Circle)*    Spouse    Child    Other				

**I give permission for my insurance company to be billed for the cost of this vaccination. I understand that if insurance does not cover the cost of this service, I will be responsible for the cost. If this vaccination is for a child under 18 years of age, I give permission for my child to be vaccinated.**

X \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature of patient, parent or legal guardian)

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**For Clinic/Office Use Only:**

Date vax given:	Vax Type	Vax Manufacturer	Exp. Date/ Lot No	Dose	State Supplied	Preserv Free	Injection Site (Circle)	Route (Circle)	Date On VIS	Date VIS given
	TIV LAIV			0.5 ml	Yes No	Yes No	Intranasal Intramuscular Intradermal	R Arm L Arm R Leg L Leg	7/26/11	
	PPV23			0.5 ml	Yes No		Intramuscular Subcutaneous	R Arm L Arm R Leg L Leg	10/6/09	

Clinic Site Name: \_\_\_\_\_ Arlington Board of Health \_\_\_\_\_ MDPH Provider PIN#: \_\_\_\_\_ 11828 \_\_\_\_\_

Clinic Address: \_\_\_\_\_ 27 Maple St, Arlington, MA 02476 \_\_\_\_\_

Signature of Vaccine Administrator: \_\_\_\_\_ Date: \_\_\_\_\_