Indiana Department of Health COVID-19 Vaccination Patient Intake Form

First Name	MI Last Nan	ne	DOB	Mobile Phone	
Address		Email			
City	State	Zip Code	Gender M	Pregnant? F Y N	
Preferred Language: Preferre	red Language: Preferred Ethnicity: Preferred Race:		Employer Name		
Is the patient sick today?					
Y N		Primary Medical Insurance Carrier			
Does the patient have allergie food, a vaccine component, o		Policy Number			
Has the patient ever had a sen after receiving a vaccination? Y		Group ID (If Pr	resent)		
Risk Factors (Circle all that a	pply)	Policy Holder			
	PATIENT CO	NSENT FOR COVII	D-19 VACCINATION	N	
Reason for Vaccination (Circle all that apply)	Notice of Priva	acy Practices			
	Vaccine Informati	ion (Only for office p	personnel use)		
Vaccine Name	VIS/EUA	VIS/EUA Date			
CXV Code	Expiration	Expiration Date		tering Facility	
Lot Number	Administ	Administration Site		tration Date	
Manufacturer	Administ	Administration Route			

