

2010 ADULT FLU SHOT CHECK-IN FORM

LAST NAME _____ FIRST NAME _____ MIDDLE INIT _____

DATE OF BIRTH _____ SSN _____

SEX: M F MARITAL STATUS: SINGLE MARRIED DIVORCED SEPARATED WIDOWED

ETHNICITY (CIRCLE ONE): HISPANIC NON-HISPANIC

RACE (CIRCLE ONE) IF MULTI RACIAL CIRCLE AT LEAST TWO: WHITE BLACK ASIAN INDIAN CHINESE

AMERICAN INDIAN/ALASKAN NATIVE ASIAN INDIAN ASIAN OTHER FILIPINO GUAMANIAN CHARMORRO JAPANESE

HAWAIIAN NATIVE KOREAN SAMOAN PACIFIC ISLANDER/OTHER VIETNAMESE UNKNOWN OTHER _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ PHONE # _____

ALLERGIES? YES NO IF YES, PLEASE LIST _____

PAYMENT METHOD (CIRCLE ONE): SELF PAY (\$28 for seasonal flu)

MEDICARE NUMBER: _____
(HAVE MEDICARE CARD AVAILABLE)