Wildflower Pediatrics, PA
11609 Anderson Mill Road
Austin, Texas 78750

DATE_____

DEMOGRAPHIC DATA

NAME: _____MIDDLE_____LAST_____DOB_____SEX_____

RACE_____ETHNICITY_____

HOME ADDRESS_____CITY_____STATE_____ZIP_____

PHONE NUMBER_____ALLERGIES_____

INSURANCE INFORMATION

NAME OF COMPANY_____

SUBSCRIBER NUMBER_____

GROUP NUMBER_____

DATE OF BIRTH OF SUBSCRIBER_____

ADDRESS IF DIFFERENT FROM PATIENT_____

_____

TO BE FILLED OUT BY STAFF

VACCINE_____

MANUFACTOR_____

LOT # _____

SITE_____

DATE OF ADMIN_____

I (OR MY AUTHORIZED REPRESENTATIVE) CONSENT TO THE COVID-19 VACCINE BY WILDFLOWER PEDIATRICS.

I AUTHORIZE THE CLINIC TO RELEASE MEDICAL INFORMATION TO THIRD PARTY INSURANCE CARRIERS FOR THE PURPOSE OF FILING INSURANCE CLAIMS RELATED TO THE ADMINISTRATION OF THE COVID-19 VACCINE.

PATIENT OR GUARDIAN NAME_____

RELATIONSHIP TO PATIENT_____

SIGNATURE_____ DATE_____