COLUMBIA GORGE
FAMILY MEDICINE

# *COVID-19 VACCINE CONSENT FORM*

**Information about person to receive vaccine (please print)**

**Name**: _____ **Birth date**: ___/___/_____ **Age**: _____ **Sex**: ☐ Male ☐ Female

**Race**: ☐Asian ☐Black ☐Native American ☐Pacific Islander ☐White ☐Other **Ethnicity**: ☐Hispanic ☐Non-Hispanic

**Address**: _____ **City**: _____ **State**: _____ **Zip**: _____

**Phone**: _____ **Do you have insurance?** ☐ No ☐ Yes

## INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Primary Insurance: _____
Subscriber's Name:_____Date of birth: _____
Group No: _____
Policy No: _____
Client's relationship to subscriber: _____

Secondary Insurance: _____
Subscriber's Name:_____Date of birth: _____
Group No: _____
Policy No: _____
Client's relationship to subscriber: _____

The above information is true to the best of my knowledge. If qualified, I authorize billing to my insurance company and release of information required to process my claims.
I authorize my insurance benefits be paid directly to CGMF.

Client Signature_____Date_____