701 E Rosser Ave
Bismarck, ND 58501
701-751-9500
www.cfmbismarck.und.edu

Flu Shot Information Sheet

Last Name:		First Name:		MI:
Address:		City:	State:	Zip:
Phone:	Gender: ⦿ Male ◯ Female	Birthdate:		Age:

For Minors receiving the vaccine please complete the responsible party information:

Name:	Gender: ⦿ Male ◯ Female	Phone:		Birthdate:
Address (if different from above):		City:	State:	Zip:

Primary Insurance (including Medicare Part B):

Insurance Company:	Policy Number:	Group Number:
Policy Holder Name:	Policy Holder DOB:	Relationship to Patient:

Secondary Insurance (including Medicare Part B):

Insurance Company:	Policy Number:	Group Number:
Policy Holder Name:	Policy Holder DOB:	Relationship to Patient:

I hereby authorize UND Center for Family Medicine the release of all medical information necessary to process any insurance claim led on my behalf. I understand I am financially responsible for all charges. I acknowledge I have received or am able to obtain a copy of the UND Center for Family Notice of Patient Privacy Practices. I also acknowledge that I have been allowed to ask questions concerning this notice.

Signature	Date

For Internal Use Only

Manufacturer: Sanofi MedImmune GSK	Lot
Admin Site: R / L Deltoid Thigh	VIS Sheet
Nurse	Physician
Occult screening cards given: Yes / No Occult Screening Handout given: Yes / No	