NABHCO CLINIC

COVID-19 Vaccine Registration Form

Name *

First Name Last Name

Social Security Number *

Birth Date *

Month Day Year

Gender *

Female Male

Email *

example@example.com

Phone Number *

Please enter a valid phone number.

Address *

Street Address

Street Address Line 2

Insurance Company *

If none, list N/A

Insurance ID

Health and Medical History

Do you have any chronic health condition? *

Please indicate all health issues that are considered within the risk group. If none, list N/A.

Please check the symptoms that apply

- ☐ None
- ☐ Body aches
- ☐ Diarrhea
- ☐ Difficulty in breathing
- ☐ Nasal congestion
- ☐ High fever
- ☐ Loss of taste or smell
- ☐ Runny nose
- ☐ Cough
- ☐ Persistant pain or pressure on chest
- ☐ Sore throat
- ☐

Have you been diagnosed with COVID-19? *

- ○ Yes
- ○ No

If yes, please provide further details (date of diagnition, were you hospitalized or not, treatment, etc.)

I hereby declare that all the given information are accurate. *