TROTT'S CALL FIELD DRUG VACCINE RECORD

PROVIDER IDENTIFICATION NUMBER PHO 323

Type of vaccine(s) getting: _____

METHOD OF PAYMENT: Cash Credit Card Check Insurance Plan

For insurance plan, we need the following information:

Bin# Grp# PCN# Plan ID# _____

Medicare # _____ Date of Birth: _____ Sex: M F

If you have received a vaccination here in the past and there has been a change in your Medicare status or you have gone from a Medicare D plan to a Medicare Advantage Plan, we will need to make copies of your insurance cards.

Age if under 14 years of age: _____ Home Phone: _____ Cell Phone: _____

Last Name First Name M.I.

_____ _____ _____

Address: _____ City: _____ State ___ Zip _____ County: _____

Primary physician: _____

Name, Address, & Title of person administering vaccinations:

Pharmacist Name: Charles R. Weaver, RPh

Trott's Call Field Drug, 4122 Call Field Rd, Wichita Falls, TX, 76308

I have read or have had explained to me the information in the pamphlet about the vaccination(s) I have being given today. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask the vaccine(s) be given to me or to the person named below for whom I am authorized to make this request.

Statement: I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits to the party who accepts the assignment. I am responsible for any charges not paid by insurance or other parties.

Signature: _____ **Date:** _____