TOMPKINSVILLE DRUG CO.
1513 EDMONTON RD.
TOMPKINSVILLE, KY 42167
270-487-6155

Vaccine Intake Questionnaire

Patient Name: _____ Date of Birth:_____ Gender:[ ] M or [ ] F

Ethnicity:[ ]American Indian /Alaska Native [ ] Asian [ ]Black/African American [ ]Hispanic/Latino [ ] White [ ] Other_____

Address:_____ City_____ State:_____ Zip:_____

Phone:_____ Email:_____

Are you a facility resident? If yes list Facility Name:_____ Room #_____

Responsible Party Name:_____ Address:_____ Phone:_____

Medical Insurance Payer:_____ Policy #_____ Group#_____

Payer Address:_____ Phone:_____

Insured:_____ Date of Birth:_____ Relationship:_____

Prescription Drug Plan:_____ RxBIN:_____ RxPCN:_____

Plan ID#_____ Group Number:_____

Insured:_____ Date of Birth:_____ Relationship:_____

List any known Allergies:_____

List any known Medical Conditions:_____

Primary Care Physician:_____ Phone:_____

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

HIPAA Privacy Information and Medical Records

1) I have acknowledged that I have received the provider's Inc Notice of Privacy Practices which may be provided at my request.
2) For Medicare, Medicaid, or Insurance Billing: I authorize this provider to release information and request payment. I understand that the information given by me in applying for payment is correct.
3) I authorize the release of all records to act on this request and I request that payment of benefits be made on my behalf.

Signature of patient or guardian: _____ Date:_____