MaineHealth

COVID-19 Vaccine Registration Form

Patient First Name	
Patient Middle Initial	
Patient Last Name	
Patient Date of Birth	
Patient (Legal) Gender	
Last 4 Digits of Social Security #	
Patient Language	
Interpreter Needed (Yes/No)	
Mailing Address: Street Address	
Mailing Address: City	
Mailing Address: State	
Mailing Address: Zip Code	
Mailing Address: County	
Physical Address (if different from mailing address):	
Phone Number: Mobile	
Phone Number: Home	
Insurance Identification Number/ Policy Number/ Member ID #	
Insurance Company Name	
Ethnicity:	☐ Hispanic ☐ Non-Hispanic ☐ Unknown
Race:	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Multi-Racial ☐ Native Hawaiian or Other Pacific Islander ☐ White or Caucasian ☐ Unknown