



MAXEM HEALTH URGENT CARE

P.O BOX 1248
OCEAN SPRINGS, MS 39566
Phone: 228-223-1927

PATIENT INFORMATION: COVID VACCINE

PLEASE HAVE PICTURE I.D. AND INSURANCE CARDS AVAILABLE FOR STAFF.

LAST NAME: _____ FIRST NAME: _____ M.I. _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME #: _____ WORK : _____ CELL #: _____

SSN: _____ DATE OF BIRTH: _____

GENDER: MALE / FEMALE MARITAL STATUS: MARRIED SINGLE WIDOW DIVORCED

DRIVER'S LICENSE #: _____

EMPLOYMENT STATUS: F/T P/T RETIRED UNEMPLOYED DISABLED

NOTIFY IN CASE OF EMERGENCY:

LAST NAME: _____ FIRST NAME: _____ M.I. _____

RELATIONSHIP TO PATIENT: _____

HOME #: _____ WORK : _____ CELL #: _____

NOTICE TO ALL INSURANCE PATIENTS

I authorize the release of any information concerning my health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the Physician. We will file this COVID-19 shot injection with your insurance company. In the event of nonpayment, you will NOT be responsible for the charges incurred today.

Patient/Guardian Signature: _____ Date: _____