

Lees Summit Physicians Group, Inc.

FLU VACCINE PROGRAM

PATIENTS NAME \_\_\_\_\_ SEX \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
MOTHERS NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SS# \_\_\_\_\_  
FATHERS NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SS# \_\_\_\_\_  
HOME ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
FATHERS EMPLOYER \_\_\_\_\_ C/S/Z \_\_\_\_\_  
FATHERS WORK PHONE \_\_\_\_\_  
MOTHERS EMPLOYER \_\_\_\_\_ C/S/Z \_\_\_\_\_  
MOTHERS WORK PHONE \_\_\_\_\_

PATIENT INSURANCE INFO

CARRIER NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_  
PRIMARY INSURED NAME \_\_\_\_\_ SS \_\_\_\_\_ DOB \_\_\_\_\_  
PRIMARY INSURED EMPLOYER \_\_\_\_\_ C/S/Z \_\_\_\_\_  
PATIENTS RELATION TO INSURED \_\_\_\_\_  
POLICY NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

SECONDARY INSURANCE

CARRIER NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_  
PRIMARY INSURED NAME \_\_\_\_\_ SS \_\_\_\_\_ DOB \_\_\_\_\_  
PRIMARY INSURED EMPLOYER \_\_\_\_\_ C/S/Z \_\_\_\_\_  
PATIENTS RELATION TO INSURED \_\_\_\_\_  
POLICY NUMBER \_\_\_\_\_ GROUP NUMBE \_\_\_\_\_

\_\_\_\_\_  
PATIENT/PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE