DATE:_____ CHART #_____

# IMMUNIZATION REGISTRY RECORD WORKSHEET

VFC: YES OR N

## PATIENT INFORMATION

**Name:** First _____ Last _____ Middle _____

**Birth Date:** _____ **State and Country where born in:** _____

**Gender** (please circle): Male or Female

**Race** (please circle all that apply): Aleut, Arabian, Asian Indian, Black, Cambodian, Chinese, Eskimo, Filipino, Guamian, Hawaiian, Indian, Japanese, Korean, Laotian, Other Asian or Pacific, Samoan, Thailander, Vietnamese, White, Other (please specify)_____

**Hispanic Origin:** Non-Hispanic, Cuban, Mexican, Puerto Rican, South or Central American (please circle) (South & Central America includes: Argentina, Belize, Bolivia, Brazil, Chile, Columbia, Costa Rica, Ecuador, El Salvador, French Guiana, Guatemala, Guyana, Honduras, Nicaragua, Panama, Paraguay, Peru, Suriname, Uruguay, Venezuela) Other (please specify):_____

**Language:** _____ **Social Security #:**_____

**Health Plan** (please circle): No Insurance, Medicaid (Access, Gateway, Unison) Medicare, Private Ins (please specify) _____

**School District:**_____ (please circle) **Graduate** or **GED** **Year:**_____

## PATIENT INFORMATION

**Address:**_____ **City:**_____ **State:**_____

**Zip Code:**_____ **County:**_____ **Primary Phone #:**_____

**Drug Allergies or Contraindications** (if applicable):_____

_____

**Please circle only one (either):** **Have you had the Chicken Pox :** **Yes or No** **OR**

**Have you had the Vaccine for the Chicken Pox:** **Yes or No**

## PARENT OR GUARDIAN INFORMATION (Adults please fill this section out as well)

**Mother Name:** First_____ Last_____ Middle_____

**Maiden Name:**_____ **Social Security #**_____

**Father Name:** First_____ Last_____ Middle_____

**If you have a different Primary Care Physician (PCP) other than Bayside Family Medicine. Please List information:**

**PCP Name:**_____ **PCP Phone #:**_____

**PCP Address:**_____