Case Registration Form

v 1.7

Facility ID Number	(auto filled)
Case Registration Date	____/____/_________ (mm/dd/yyyy)
1. Patient Information	
Patient ID	(auto filled)
*Social Security Number or Other ID	SSN: _______ - ______- ___________ Or Other ID: ________________________ Description:_____________________________ (e.g. SIN)
*First Name	____
Middle Name	____
*Last Name	____
*Old Medicare Beneficiary ID *(prior to April 2018)*	___________________________________
*New Medicare Beneficiary ID *(April 2018 or later)*	___________________________________
*Date of Birth	____/____/_________ (mm/dd/yyyy)
*Patient Sex	Select one: O Male O Female O Other O Unknown
Race	Select one: O American Indian or Alaska Native O Asian O Black or African American O Unknown O Native Hawaiian or Pacific Islander O White O Other O Not Reported
Hispanic Origin	O No O Yes O Not Reported O Unknown
Health Insurance	Select all that apply: O Medicare O Medicaid O Private Insurance O Self Pay O VA O Unknown O Other, please specify: ________________________
Education Level	Select one: O 8th Grade or less O 9th-11th Grade O High School Graduate or high school equivalency O Post high school training, other than college (vocational /technical school) O Associate degree/some college O Graduate or professional school O Bachelor's degree O Unknown/refused to answer O Other, please specify: ________________________
COVID Vaccine	O Yes O No O Unknown
COVID Vaccine Date	____/____/_________ (mm/dd/yyyy)
COVID Vaccine Manufacturer	Select one: O Johnson & Johnson Janssen O Moderna O Novavax O Oxford-AstraZeneca O Pfizer-BioNTech O Unknown O Other, please specify: ________________________
COVID Vaccine Site	Select one: O Right arm O Left Arm O Other O Unknown
2. *Date of Exam	____/____/_________ (mm/dd/yyyy)

3. Name of Person Who Completed this Paper Form	
*First Name	________________________
*Last Name	________________________

Note: Asterisked (*) fields indicate required data elements.