Venice Family Clinic

Registration Form

(Please print) Today's Date:

Patient's Legal Name:

Last: *First:* *Middle:*

Parent or Guardian's First Name:

Patient's Date of Birth: / /

Address:

Number/Street:

City: *State:* *Zip:*

Primary Phone: ( ) -

Email:

Preferred Language:

- ☐ English
- ☐ Spanish
- ☐ American Sign Language
- ☐ Another language (please specify): _____

Patient Status

- ☐ I'm currently a patient
- ☐ I'm not currently a patient
- ☐ I'm not a patient, but I would like to be a patient

Living Situation:

- ☐ Not currently homeless/I have housing
- ☐ Permanent Supportive Housing

I am currently homeless, and the place I most often sleep is:

☐ Shelter ☐ Doubled Up ☐ Other
☐ Transitional ☐ Street ☐ Unknown

We ask questions about demographics to ensure equitable care, and because of grants and funding requirements. You may decline to disclose your race and/or ethnicity.

Race:

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ I choose not to disclose
- ☐ Race not listed

Sex Assigned at Birth:

- ☐ Male
- ☐ Female
- ☐ Prefer Not to Say
- ☐ Non-Binary

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ I choose not to disclose

Insurance or Health Coverage:

☐ Medi-Cal ☐ Medicare ☐ My Health LA ☐ No Insurance
☐ Private Insurance ☐ Something else: _____

Health Insurance Carrier : _____

Medical Record Number/ Policy Number: _____

COVID Vaccine is provided at no cost to eligible individuals. Primary Medical Coverage information is for our records only.

STAFF ONLY: **Clinic Site:** _____

COVID Vaccines

Moderna (6mth - 5y): ☐ Dose 1 ☐ Dose 2 ☐ Booster (Bivalent)
Moderna (6yo - 11y): ☐ Dose 1 ☐ Dose 2 ☐ Booster (Bivalent)
Moderna (12y+): ☐ Dose 1 ☐ Dose 2 ☐ Booster (Bivalent)

Pfizer (6mth - 4yo): ☐ Dose 1 ☐ Dose 2 ☐ Dose 3 (Bivalent)
Pfizer (5yo - 11yo): ☐ Dose 1 ☐ Dose 2 ☐ Booster (Bivalent)
Pfizer (12yo+): ☐ Dose 1 ☐ Dose 2 ☐ Booster (Bivalent)

Flu Vaccines

Vaccines for Children (≤18y):
☐ Fluzone Quad ☐ Fluarix Quad ☐ Flulaval Quad
☐ Flumist Quad

Patients (19y-64y):
NI: ☐ Fluarix Quad
I: ☐ Flulaval Quad ☐ Fluzone Quad

Patients (65y+):
☐ Flublok Quad ☐ Fluzone HD Quad

Date and Time of Vaccination: _____ **Injection Site:** ☐ Left Arm ☐ Right Arm ☐ Left Leg ☐ Right Leg

Vaccine Administrator: _____ **Lot Number:** _____ **Route:** Intramuscular