Soledad Medical Clinic
600 Main St Soledad, CA 93960
Tel 831-678-2665 Fax 831-678-0776
www.soledadmedicalclinic.com

New Patient Registration Forms
COVID19 Vaccine Administration

Name: ________________________ Date of Birth: _______________________

Phone #: ______________________ Address: ___________________________

City: __________________ State: _________ Zip Code: ___________________

Email address: _____________________________________

Primary Care Doctor: ________________________________

Employer Name: ____

Job Title: _____________________ Employer Phone #: ______________________

Job status: full time part time Advanced Directive: _______Yes ______No

Marital Status: ____________________________Organ Donor: _______Yes ______No

Reason for Visit: ________COVID19 VACCINE_______

Date of Vaccine: _________________ Dose: _______1st Dose ______2nd Dose

Emergency Contact Name: ____

Emergency Contact Phone #: ________________ Relationship to Patient:____________

If Patient is a MINOR: Name of Parent: ___________________________________

Parents Date of Birth: ____________________________________

****I consent to having the COVID19 vaccine administered. I have been counseled on the risks.*

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Signature Date