Takashi Yoshida, MD **2490 Hospital Dr. #103, Mountain View, CA** **(650) 962-4640**

Vaccine Registration Form

Your Child's Name: _____

Patient's Name:_____ Birth Date:_____

Address: _____ City:_____ Zip Code: _____

Phone# ( ) _____ Email: _____

Insurance: _____ Subscriber ID# _____ Group#_____

Insured Person: _____ Birth Date: _____

I understand my signature requests that payment be made to Takashi Yoshida, MD, Inc and authorized release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 insurance form, my signature authorizes releasing of the information to the insurer. **In the event, any insurance claims are not paid, I will be responsible for the balance on the account.**

Signature: _____ Date: _____

****

OFFICE USE ONLY

Influenza Vaccine _____
Lot# _____

Date: _____

Other Vaccine: _____
Lot# _____

Initials: _____