



FLU WAIVER

Date: _____

Patient's Name: _____ DOB: _____ SS#: _____

Home Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer Name: _____ Employer Address: _____

Email Address: _____

Allergies: _____

Name of pediatric patient in practice: _____ Relation: _____

PLEASE ENTER CREDIT CARD NUMBER AND EXPIRATION DATE

Card Holder's Signature: _____