Lindsborg Community Hospital
Salina Regional Health Center
Partners caring for the health of the Smoky Valley communities.

Registration Quick Form

Department: _____

Date/Time: _____

Ordering Provider: _____

Last Name: _____ Middle Initial: _____ First Name: _____

Gender: Male / Female SSN: _____ Date of Birth: _____

Marital Status: Married Single Widowed Preferred Language: _____

Race: _____ Ethnic Group: Hispanic/Latino or Non-Hispanic/Latino

College Student? Y / N If yes, box number at campus: _____ Email: _____

Current Address: _____

City: _____ State: _____ Zip: _____

Cell Number: _____ Home Phone: _____

If under 18 years if age: What is parent/guardian's full name? _____

Health Insurance: _____ Policy/ID# _____ Grp# _____

Primary Care Physician/Provider: _____

Guarantor Information (who is responsible for paying the bill):

Name: _____ Relationship to you: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Number: _____ Home Number: _____

Closest Living Relative: Name: _____ Relationship to you: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Number: _____ Home Number: _____

Notify in Case of Emergency: ☐ ***Check here if same as closest living relative***

Name: _____ Relationship to you: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Number: _____ Home Number: _____

Please Note: This form is used for sports physicals, DOT physicals and flu vaccination clinics. It does not indicate that our providers have accepted you as a patient for ongoing primary care.

Your Signature: _____ Date: _____

Lindsborg Community Hospital
Salina Regional Health Center
Family Health Care Clinic

605 W Lincoln • Lindsborg, KS 67456 • 785-227-3371 • FAX 785-227-3004 • www.lindsborghospital.org

Patient Name: _____

Date of Birth: _____ Primary Care Provider: _____

____yes ____ no Severe allergy to eggs or thimerosal or latex?

____yes ____ no Previous severe reaction to influenza vaccine?

____yes ____ no Moderate to severe illness today?

____ yes ____ no Ever paralyzed with Guillain-Barre within 6 weeks after flu shot?

I have been offered or provided, whether accepted or not, a copy of the "Vaccine Information Statement.I have read, or have had explained to me, the information in the "Vaccine Information Statement." My questions have been answered satisfactorily, and I ask that the vaccine be given to me or to the person for whom I am authorized to make this request. I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself and on behalf of person I am responsible for.

Patient Signature: _____ Date: _____

Vaccination Record **FOR ADMINISTRATIVE USE ONLY**

Flu Dose Brand: High Dose / Regular / Egg Free Lot/Exp:

Dose Amount: __0.5 mL___ VIS: ___01/31/2025___Site Given: Temp:

Signature: _____ Date: _____