COVID-19 Billing & Consent Form

Patient Information

First Name: _____ **Last Name:**_____ **Sex (circle):** M F

Address:_____ **City:**_____

State:_____ **Zip Code:**_____ **County:**_____

Birth Date:_____ **Age:**_____**Phone Number:**_____

Race: ☐ Asian/Pacific Islander ☐ Black ☐ Native American/Alaskan Native ☐ White ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Prescreening Questions

1. Are you feeling sick today? Yes____ No____
2. Have you had any vaccinations in the past 14 days? Yes____ No____
   If yes, which vaccination? _____
3. Have you received the first dose of COVID-19 vaccine? Yes____ No____
   If yes, which vaccine product did you receive?
   ☐ Pfizer ☐ Moderna ☐ Another product_____
4. Have you ever had a severe allergic reaction (e.g. anaphylaxis)? For example, a reaction for which you were treated with epinephrine or EpiPen, or which you had to go to the hospital? Yes____ No____
   - Was the severe allergic reaction after receiving a COVID-19 vaccine? Yes____ No____
   - Was the severe allergic reaction after receiving another vaccine or injectable medication? Yes____ No____
     If yes, which vaccine/medication?_____
5. Have you ever had a COVID-19? Yes____ No____
6. Have you received plasma within the last 90 days while sick in the hospital with COVID-19? Yes____ No____
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? Yes____ No____
8. Do you have a bleeding disorder or are you taking a blood thinner? Yes____ No____
9. Are you pregnant or breastfeeding? Yes____ No____
10. Do you have dermal fillers? Yes____ No____

I have received a copy of the Emergency Use Authorization Fact Sheet regarding the disease and vaccine and understand there is a risk of slight to severe reaction with any vaccination. I also understand that this is a less risk than the risk of an unvaccinated person who could acquire this disease. By signing this form, I also grant permission for this record to be released to medical providers, health departments and to be transmitted to the immunization registry.

Patient/Guardian Signature:_____ Date:_____

Printed Name: _____

OFFICE USE ONLY

Site (circle): Left Arm Right Arm

Manufacturer:_____

Lot #:_____

Diagnosis Code:_____Z23___

Insurance: _____

ID Number: _____

Bin: _____ **PCN:**_____

Group: _____

Vaccinator: _____ **Date:** _____