PATIENT INFORMATION

Name: ______________________ Date of Birth: ______________

Gender: ______________________

Address: ______________________

City, ST ______________________ ZIP Code: ______________

County: ______________________

Contact Mobile Phone: ______________________

Contact Email Address: ______________________

Preferred Communication Method (Text Message or Email) ______________

DEMOGRAPHICS:

Preferred Language: ____________ Hispanic? ☐ YES ☐ NO Race: ______________

Medical Insurance Carrier: ______________________

Policy Number/ID: ______________ Group No. (if known): ______________

Policy Holder: ☐ Myself ☐ My Spouse ☐ My Parent ☐ Other

HEALTH HABITS

Is patient sick today? ☐ YES ☐ NO Is the Patient Pregnant? ☐ YES ☐ NO

Does patient have allergies to medication, food, vaccine component or latex? ☐ YES ☐ NO

Has patient ever had a serious reaction after receiving a vaccination? ☐ YES ☐ NO

Is the patient disabled? ☐ YES ☐ NO

Health Risk Factors (check all that apply):

☐ Obesity ☐ Over the Age 65 ☐ Active Cancer Treatment ☐ Chronic Kidney Disease

☐ COPD ☐ Serious Heart Condition ☐ Sickle Cell Disease ☐ Active Dialysis Patient

☐ Diabetes ☐ Solid Organ Transplant ☐ Cystic Fibrosis

☐ Down Syndrome ☐ Other: ______________________

Reason for receiving the vaccine: ______________________

CONSENTS (see attached)

PATIENT CONSENT FOR COVID-19 VACCINATION: ☐ ACCEPTED ☐ NOT ACCEPTED

NOTICE OF PRIVACY PRACTICES: ☐ ACCEPTED ☐ NOT ACCEPTED

Signed by: ______________________ Relationship to Patient: ______________

Emergency Contact Number: ______________________

Employer Name: ______________________