Mayflower Family Pharmacy
616B AR-365
Mayflower, AR 72106
PH:501-470-9898
FAX: 501-470-9895

Vaccine Intake Questionnaire

Patient Name: _____ Date of Birth:_____

Social Security # _____ Gender:[ ] M or [ ] F

Ethnicity:[ ]American Indian /Alaska Native [ ] Asian [ ]Black/African American [ ]Hispanic/Latino [ ] White [ ] Other_____

Address:_____ City_____ State:_____ Zip:_____

Phone:_____ Email:_____

Medical Insurance Payer:_____ Policy #_____ Group#_____

Payer Address:_____ Phone:_____

Insured:_____ Date of Birth:_____ Relationship:_____

Prescription Drug Plan:_____ RxBIN:_____ RxPCN:_____

Plan ID#_____ Group Number:_____

Insured:_____ Date of Birth:_____ Relationship:_____

List any known Allergies:_____

List any known Medical Conditions:_____

Primary Care Physician:_____ Phone:_____

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

HIPAA Privacy Information and Medical Records

1) I have acknowledged that I have received the provider's Inc Notice of Privacy Practices which may be provided at my request.
2) For Medicare, Medicaid, or Insurance Billing: I authorize this provider to release information and request payment. I understand that the information given by me in applying for payment is correct.
3) I authorize the release of all records to act on this request and I request that payment of benefits be made on my behalf.

Signature of patient or guardian: _____ Date:_____

Which arm do you prefer we use for today's vaccine? (circle one) L or R

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Covid Vaccine Consent and Administration

Patient Name: _____ Date of Birth:_____

Have you had a previous COVID-19 vaccine? If yes, date? _____

Have you had other vaccines in the past **2 weeks**? If Yes, what was given and when:_____

Please answer the following questions:	**Yes**	**No**	**Don't Know**
1. Are you sick today? (For example: a cold, fever, acute illness)	☐	☐	☐
2. Do you have allergies to Polyethylene glycol or any other vaccines in the past? Please list_____	☐	☐	☐
3. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☐	☐
4. Do you have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
5. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
6. Have you ever had a reaction after receiving a vaccine, including feeling faint or dizzy?	☐	☐	☐
7. Have you received monoclonal antibodies or convalescent plasma for COVID-19 treatment? *The COVID-19 vaccine should be deferred for at least 90 days to avoid interference of treatment with vaccine-induced immune responses.*	☐	☐	☐

RELEASE AND ASSIGNMENT:

- **I have read or had explained to me the Vaccine Recipient Emergency Use Authorization (EUA) Fact Sheet for COVID-19 vaccine risks and benefits. To read the Vaccine Recipient Emergency Use Authorization Fact Sheet for each vaccine visit the website www.cvdvaccine.com: or you may also visit the Local Health Unit or private provider to receive a printed copy of the EUA Fact Sheet. To read the Vaccine Recipient Emergency Use Authorization for Moderna COVID-19 vaccine visit the website** https://www.fda.gov/media/144638/download or (modernatx.com)
- **I give consent to this COVID-19 provider/staff for the individual named below to be vaccinated with COVID-19 vaccine.**
- **I hereby acknowledge that I have reviewed a copy of the Provider's Privacy Notice.**
- **I understand that information about this COVID-19 vaccination will be included in (WebIZ) Arkansas Immunization Information System.**

To My Insurance Carrier(s):

- **I authorize the release of any medical information necessary to process my insurance claim(s).**
- **I authorize and request payment of medical benefits directly to this COVID-19 Provider.**
- **I agree that the authorization will cover all medical services rendered until I revoke the authorization.**
- **I agree that the photocopy of this form may be used instead of the original.**

Signature of patient or guardian: _____ Date:_____

OFFICE USE ONLY BELOW THIS LINE

Administration Date:_____

[ ] COVID19 1st Dose [ ] Moderna (codes: 91301 & 0011A)

[ ] COVID19 2nd Dose Brand and Date first dose was given:_____ [ ] Moderna (codes: 91301 & 0012A)

Dose Given:___0.5 ml_____

Lot#_____

Exp Date:_____

Administration site:_____

Immunizer:_____

Affix Rx Label Here