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 __
   It yes, which vaccination? _____
3. Have you received the first dose of the 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?
   - 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? If yes, which Vaccine/medication? _____ Yes __ No __
5. Have you received. plasma within the last 90 days while sick in the hospital with COVID-19 Yes __ No __
6. Do you have a weakened immune system caused by something such HIV infection or cancer or do you take immunosuppressive drugs or therapies? Yes __ No __
7. Do you have a bleeding disorder or are you taking a blood thinner? Yes __ No __
8. Are you pregnant or breastfeeding? 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: _____

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Manufacturer: Moderna Site (Circle): Left Arm Right Arm
Diagnosis Code: Z23 Medicare Number: _____ Insurance: _____
ID Number: _____ Group Number: _____
Patient's Target Population Occupation: _____
(Example: Over the age of 80, healthcare worker, etc)

Vaccinator:_____ Date: _____