Midtown Pharmacy 278 N 3rd Street Gadsden, Al 35901 256-543-7777

Vaccine Intake Questionnaire

Patient Name:	Date of Birth:	Gender:[]M or []F			
Ethnicity:[]American Indian /Alaska Native [] Asian []Bla	ack/African American []Hispani	c/Latino [] White [] Other			
Address:	City	State: Zip:			
Phone: Email:					
Are you a facility resident? If yes list Facility Name:		Room #			
Responsible Party Name:					
Medical Insurance Payer:	Policy #	Group#			
Payer Address:	Phone:				
Insured:	Date of Birth:	Relationship:			
Prescription Drug Plan:					
Plan ID# Group	Number:				
Insured:	Date of Birth:	Relationship:			
List any known Allergies:		2			
List any known Medical Conditions:		w			
Primary Care Physician:	Phone:				
Address:) b);			
BRISTORY CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CO	3	The state of the s			
HIPAA Privacy In I have acknowledged that I have received the provider's For Medicare, Medicaid, or Insurance Billing: I authorize information given by me in applying for payment is cortain authorize the release of all records to act on this request.	ze this provider to release informa rect.	hich may be provided at my request. tion and request payment. I understand that the			
Signature of patient or guardian:		Date:			

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Vaccine Consent and Administration

Petient Name:	230 343 1111				
Please answer the following questions: 1. Are you sick today? (For example: a cold, fever, acute illness)	Patient Name:	Date of Birth:			
Please answer the following questions: 1. Are you sick today? (For example: a cold, fever, acute illness) 2. Do you have allergies to medications, food, or any vaccine? (For example eggs, gelatin, neomycin, Thimerosal, latex, etc.) Please list ggs, gelatin, neomycin, Thimerosal, latex, etc.) Please read ALL of the following 3 statements, if consent is given please and sign and date below. Please read ALL of the following 3 statements, if consent is given, please and sign and date below. 1) I have been provided with the Vaccine Information Sheet (VIS) and/or been provided with information regarding to the vaccine 1 am receiving. 2) I understand all the benefits and risks of the vaccine and have had the chance to ask questions regarding it. I voluntarily assume full responsibility for any reactions that may result. 3) I request the vaccine be given to me and authorize and direct this health care provider to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information during the term of this Authorization to the physician responsible for purposes of treatment, payment or other health (PCP), my insurance plan and/or state federal registries, where required for purposes of treatment, payment or other health vaccination received today. This authorization will remain in effect until my health care provider discloses my health vaccination received today. This authorization will remain in effect until my health care provider discloses my health and state law governing the use and disclosure of my health care provider authorization or applicable feder health inform	What vaccine(s) are you seeking today?: [] Influenza [] Pr	neumonia [] COVID [] Other:			
Please answer the following questions: 1. Are you sick today? (For example: a cold, fever, acute illiness) 2. Do you have allergies to medications, food, or any vaccine? (For example eggs, gelatin, neomycin, Thimerosal, latex, etc.) Please list ggs, gelatin, neomycin, Thimerosal, latex, ggs, ggs, gelatin, neomycin, Thimerosal, latex, ggs, gelatin, neomycin, latex, ggs, gelatin, neomycin, latex, ggs, gelatin, neomycin, latex, ggs, ggs, gelatin, neomycin, latex, ggs, gelatin, neomycin, latex, ggs, ggs, gelatin, neomycin, ggs, ggs, ggs, ggs, ggs, ggs, ggs, gg	Have you had other vaccines in the past 4 weeks? If Yes, what v	vas given and when:			D 14 1/
1. Are you sick today? (For example: a cold, fever, acute illness) 2. Do you have allergies to medications, food, or any vaccine? (For example eggs, gelatin, neomycin, Thimerosal, latex, etc.) 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? Please read ALL of the following 3 statements, if consent is given, please and sign and date below. 1) I have been provided with the Vaccine Information Sheet (VIS) and/or been provided with information regarding to the vaccine la merceiving. 2) I understand all the benefits and risks of the vaccine and have had the chance to ask questions regarding it. I voluntarily assume full responsibility for any reactions that may result. 3) I request the vaccine be given to me and authorize and direct this health care provider to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information for people vaccinated by this provider (standing order practitioner (Dr					
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Exp Date:	[] Influenza (once per flu season) Brand/NDC: [] Pneumonia (once every 5 years) Brand/NDC: [] COVID19 1st Dose Brand: [] Pfizer-Biontech (codes: 91300 & 0001A) [[] COVID19 2nd Dose Brand and Date first dose was given: Brand: [] Pfizer-Biontech (codes: 91300 & 0002A) [VIS Published Date: Dose Given: Lot# Exp Date:] Moderna (codes: 91301 & 0011A) [] AstraZe	eneca (c		