

Last Name		First Name		Middle Initial	Date of Birth	Age:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
Street Address				City	County	State	Zip Code
Phone Number () <input type="checkbox"/> Cell <input type="checkbox"/> Home	Social Security #		Ethnicity: Hispanic Origin <input type="checkbox"/> Yes <input type="checkbox"/> No	Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander			
Email Address:			If Under 18-Parent/Guardian Full Name & Phone				

Medical Insurance Information

Does patient have medical health insurance Yes No If yes, please complete questions below

<input type="checkbox"/> Medicaid/Soonercare	Medicaid Number:	First and Last name as it appears on card	Mothers Maiden Name:	
<input type="checkbox"/> Private Insurance	Indicate Primary insurance:	Policy Holder:	Group No.:	Policy No.:
	Indicate Secondary insurance:	Policy Holder:	Group No.:	Policy No.:
<input type="checkbox"/> Medicare	Do you have Medicare Part B: <input type="checkbox"/> Yes <input type="checkbox"/> No	Is Medicare Primary? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Number:	

Medical Screening

- | | |
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| <p>1. Do you have a fever (>100F), infection or current illness today? Yes No</p> <p>2. Have you ever had a significant allergic reaction to a vaccine or other injection? Yes No</p> <p>3. Are you pregnant, plan to be pregnant or currently breastfeeding? Yes No</p> <p>4. Have you received passive antibody therapy as treatment for COVID-19? Yes No</p> | <p>5. Do you have a severely immunocompromising condition? Yes No</p> <p>6. Do you have a bleeding disorder or are you taking a blood thinner? Yes No</p> <p>7. Do you have an allergy to a component of the vaccine? Yes No</p> <p>8. Have you received another vaccine in the last 14 days? Yes No</p> |
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Consent: I, the undersigned, give my consent for the services that I am requesting from Passport Health and its entities/contractors. I acknowledge that I received the Vaccine Manufacturer COVID-19 Fact Sheet for Recipients and Caregivers prior to receiving the vaccine and have had the opportunity to ask questions. I understand the benefits and risks of the vaccine and request it be administered to me or the person for whom I am authorized to make consent. I may request the Notice of Health Information Practices (HIPAA) and authorize my immunization record to be recorded with the OK State Health Department and released to employer, school, and/or physician if requested.

Patient / Parent or Guardian Signature: _____ **Relationship to Patient:** _____ **Date:** _____

Office Use Only

_____	_____	_____	_____	_____	_____
Date & time	COVID Vaccine Vaccine	Manufacturer	Lot Number	Exp. Date	RA LA Deltoid Injection Site

Nurse/Vaccine Administrator: _____

DATA ENTRY
OSIS Complete?
<input type="checkbox"/> Yes
<input type="checkbox"/> No