COVID VACC PREPMOD FORM

BARTZ-ALTADONNA Community Health Center
californiahealth+

First Name _____ **Middle Initial** _____ **Last Name** _____

Mother's Maiden Name _____ **Race** _____ **Ethnicity** Hispanic

Occupation Choose one:

- ◯ Construction
- ◯ Landscaping
- ◯ Correction Officer
- ◯ Educational -Teacher, Child Care
- ◯ Farmer
- ◯ First Responder- Police,
- ◯ Firefighter, EMT Worker – No
- ◯ Direct Patient Contact
- ◯ Long Term Care – Patient / Staff
- ◯ Other: _____
- ◯ Other Essential Worker
- ◯ Plant Worker, Manufacturing,
- ◯ Machine Operator, Assembler
- ◯ Postal Worker/ Delivery
- ◯ Public
- ◯ Grocery Store Employee
- ◯ Healthcare Worker – Direct
- ◯ Patient Contact
- ◯ Healthcare
- ◯ Transit Worker
- ◯ Retired
- ◉ School Employee or contractor
- ◯ Service - Entertainment,
- ◯ Performer
- ◯ Service – Rental, Cosmetology,
- ◯ Message, Elective Services
- ◯ Service – Food Catering/
- ◯ Restaurant / Bars/ Fast Food
- ◯ Service – Transportation
- ◯ Skilled Agriculture, Forestry,
- ◯ Fishery Worker

Date of Birth _____/_____/_____ **Age:** _____ **Gender:** ☐ **MALE** ☐ **FEMALE**
month day year

Email Address (PLEASE PRINT CLEARLY) _____

Primary Phone Number _____ **Phone Number Type:** ◯ **HOME** ◯ **WORK** ◯ **CELL**

Address _____ **APT/SUITE/UNIT** _____

City _____ **State** _____ **Zip Code** _____ **County**_____

Insurance: (Choose one) ◯ Private ◯ Medicaid/Medical assistance ◯ Medicare ◯ No insurance

Do any of the following apply to you?

1. **Is this your first or second COVID-19 vaccination?** ☐ First ☐ Second
2. **Do you have any of the following chronic health conditions? ***
   - Cancer
   - Chronic Kidney Disease
   - COPD (Chronic Obstructive pulmonary disease)
   - Heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies
   - Immunocompromised state (weakened immune system) from solid organ transplant.
   - Obesity (body mass index [BMI] of 30 kg/m2 or higher but < 40 kg/m2)
   - Severe Obesity (BMT >= 40 kg/m2)
   - Pregnancy
   - Sickle Cell disease
   - Smoking
   - Type 2 diabetes mellitus *

   ☐ Yes ☐ No ☐ I don't know.
3. **Have you previously received a COVID-19 vaccine?** ◯ Yes, when?___ _____ ◯ No ◯ I don't know.
4. **Have you had a severe allergic reaction (e.g., anaphylaxis) to a COVID-19 vaccine, a component of the COVID-19 vaccine (including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures) or Polysorbate?** ◯ Yes ◯ No ◯ I don't know
5. **Have you had a severe allergic reaction (e.g. anaphylaxis) to another vaccine (not including Pfizer-BioNTech or Moderna Vaccine) or any other injectable medication?** ◯ Yes , Which one___ _____ ◯ No ◯ I don't know
6. **Do you have a bleeding disorder or are you taking a blood thinner?** ◯ Yes ◯ No ◯ I don't know

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7. **Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?** ◯Yes ◯No ◯I don't know
8. **Do you have a fever?** ◯Yes ◯No ◯I don't know
9. **Are you feeling sick?** ◯Yes ◯No ◯I don't know
10. **Are you pregnant?** ◯Yes ◯No ◯I don't know
11. **Could you become pregnant in the next several weeks?** ◯Yes ◯No ◯I don't know
12. **Are you breastfeeding (nursing)?** ◯Yes ◯No ◯I don't know
13. **Have you received another vaccine in the last 14 days?** ◯Yes, what was it? _____ ◯No ◯I don't know
14. **Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies ?** ◯Yes ◯No ◯I don't know
15. **Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?** ◯Yes ◯No ◯I don't know
16. **Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?** ◯Yes, When? _____ ◯No ◯I don't know

IMPORTANT

If you receive Moderna's vaccine, you should receive a second vaccination four weeks (28 days) later.

Please select the desired vaccine for each patient

Vaccines for: Patient Name: _____

[√] Moderna COVID-19 Vaccine (EUA Fact Sheet- See Handout)

If this is your second dose, you must get the same vaccine brand to be considered fully vaccinated.

To view the Immunization Registry Notice – See Hand Out

Consent for Vaccination - You Must Sign This to Receive this Service

In signing this form, I give permission to be vaccinated and understand that my vaccination will be entered into my local California Immunization Registry (CAIR2, HealthFutures or SIDR). Further, I agree that:

(1) The information provided is correct

(2) I have read the EUA Fact Sheet provided

(3) I understand the risks and benefits of getting the vaccine(s) and consent to be vaccinated

(4) Any questions I had about the vaccine(s) have been answered.

_____ _____

Patient or Legal Guardian Signature Date

Relation to Patient: _____

Office Use Only

Received by:_____ ***Reviewed by:***_____

Bartz-Altadonna Community Health Center
Patient Registration

Internal use Only:
Date Rec/Entered: ___/___/___
Staff Initials: _____

PATIENT INFORMATION

Last Name	First Name	MI	DOB	SS#

Street Address	City	State	Zip	County

CONTACT INFORMATION

Primary Phone: ( )___ ___ ___-___ ___ ___ ___ ◯Hm ◯Cell

Secondary Phone: ( )___ ___ ___-___ ___ ___ ___ ◯Hm ◯Cell

Employer:

Employer phone no:

BACHC may contact me for clinical/appointment reminders by using the following methods (check all that apply):
□ Email □ Home □ Cell □ Text (Standard data/messaging rates may apply)

Email:

Referred to clinic by (please check one) ☐Dr ☐Insurance Plan ☐Hospital ☐Family ☐Friend ☐Outreach ☐Social Media ☐Other:_____

PATIENT DEMOGRAPHICS

Primary Language Spoken
◯English ◯Spanish ◯Other:_____

Would you like an interpreter?
◯Yes ◯No

Race (Check all that apply)
☐ Asian ☐ Black/African American ☐ White ☐ Central American Indian
☐ American Indian/Native Alaskan ☐ Pacific Islander ☐ Native Hawaiian
☐ More than one race
☐ Other: _____

Ethnicity
☐ Hispanic/ Latino
☐ Non-Hispanic/ Latino

Gender Identity:
Do you think of yourself as:
◯Male
◯Female
◯Female-to-Male/Transgender Male
◯Male-to-Female/Transgender Female
◯Other
◯Choose not to disclose

Sexual Orientation:
Do you think of yourself as:
◯Straight or heterosexual
◯Lesbian, gay, or homosexual
◯Bisexual
◯Something else
◯Don't know
◯Choose not to disclose

Marital Status
◯Single
◯Married
◯Divorced
◯Widowed

Student
◯Full-Time
◯Part-Time
◯Not a student

Employment Status
◯Full-Time
◯Part Time
◯Not Employed
◯Retired

Housing Status: Are You Homeless? □ YES □ NO
If homeless, are you:
◯Doubling Up (living with others)
◯Shelter ◯Street ◯Transitional ◉Unknown

Gross Household Income:
$_____ ◯Monthly ◯Annually

 # Adults & Children (Under 18) In Household: _____

Military Veteran?
◯Yes
◯No

Migratory or Seasonal Agricultural Worker?
◯Yes
◯No

GUARANTOR (Person to Be Billed, Check here if same as patient □)

Last Name	First Name	MI	DOB	SS#

Street Address	City	State	Zip	Home Phone	Cell Phone

MEDICAL INSURANCE

	Insurance Company	Policy Holder Name	Relationship to patient	DOB	M/F	Employer	Zip Code
1.							
2.							

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

Assignment of Insurance Benefits, Release of Information and Authorization of Treatment.
I the undersigned authorize my insurance benefits to be paid directly to the provider of **Bartz Altadonna Community Health Center** for services render. I understand that I am ultimately financially responsible for any balance due for approved and covered charges not paid by insurance. I hereby authorize BACHC to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all my insurance claim submissions. I understand that payment is expected at the time services are rendered. A copy of this is as valid as the original.

Patient/Guardian Signature: _____ **Date:** _____

Relationship to Patient: _____

BARTZ ALTADONNA

COVID-19 Vaccine Consent Form

Section 1: Information about patient to receive Vaccine (Please Print)

Last name:	First:	M.I	Date of birth:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not, please ask your healthcare provider to explain it.

Please mark YES or NO for each question.

	YES	NO	Don't know
1. Are you feeling sick today?	☐	☐	☐
2. Have you received a dose of COVID-19 vaccine? *If yes, which vaccine product? ○ Pfizer ○ Moderna ○ Another product	☐	☐	☐
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, of for which you had to go to the hospital?	☐	☐	☐
• Was the severe allergic reaction after receiving a COVID-19 vaccine?	☐	☐	☐
• Was the sever allergic reaction after receiving another vaccine or another injectable medication?	☐	☐	☐
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐	☐
5. Have you received another vaccine in the last 14 days?	☐	☐	☐
6. Have you had a positive COVID-19 test or has a doctor ever told you that you had COVID-19?	☐	☐	☐
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐	☐
8. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
9. Are you pregnant or breastfeeding?	☐	☐	☐

Section 2: Consent

CONSENT FOR PATIENT VACCINATION:

I have read or had explained the Fact sheet for recipients and caregivers for the COVID -19 vaccine and understand the risks and benefits.

(initials) _____ **I GIVE CONSENT** to **Bartz – Altadonna Community Health Center** and its staff to be vaccinated with the COVID-19 vaccine. (If this consent form is not signed, then you will not be vaccinated)

Signature of Patient: _____ _____Date _____

Section 3: Vaccination Record **NDC:**

Vaccine	Route	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator

BARTZ-ALTADONNA Community Health Center

californiahealth

Bartz Altadonna Community Health Center

HIPAA Authorization Form

Internal use Only:

Date Rec/Entered: ____/____/____

Staff Initials: _____

Bartz Altadonna Community Health Center (BACHC) has taken measures to protect all of our patients' private medical information. BACHC will not release any information to anyone unless you have provided the requested information below. These would be people other than what is covered in our Notice of Privacy Practices.

Your protected health information will be used by BACHC or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. Please review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice and request a copy of the Notice of Privacy Practices for your own records. See the Client Services Representative to receive a copy.

You may request a restriction on the use or disclosure of your protected health information. BACHC may or may not agree to restrict the use or disclosure of your protected health information. If BACHC agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the Federal Privacy Standards.

You may revoke this consent to the use and disclosure of your protected health information. You must revoke consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Please see Client Services Representative with any questions prior to signing this authorization form.

PERSONS AUTHORIZED TO OBTAIN MEDICAL INFORMATION

Patient Name:_____If patient under 18 or has guardian, name of guardian: _____

I _____ give permission to Barta Altadonna Community Health Center to disclose health and/or billing information to the individuals identified below that are involved in patient care or payment of care. I understand BACHC is not responsible for the information provided as long as it is given to a person that I have listed below.

Date of Birth must be provided so that our office can verify that we are speaking to the correct person.

Name	Relationship	Phone	DOB
Name	Relationship	Phone	DOB

PATIENT CONSENT AND ACKNOWLEDGEMENT

I have reviewed this consent form & give my permission to BACHC to Use & Disclose my health information in accordance of the Federal Privacy Standards.

I understand that, under HIPAA laws, I have certain rights to privacy regarding my protected information. I understand that this information can and will be used for: **Treatment, Payment, and Healthcare Operations.** I have received, read and understood your Notice of Privacy Practices containing more complete description of the uses and disclosures of my health information. I understand that Bartz Altadonna CHC has the right to change its Notice of Privacy Practice from time to time and that I may contact them at any time to receive a current copy.

Patient/Guardian Signature: _____ **Date:** _____

Relationship to patient: _____

PRINT