Grapevine Drug RX

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COVID VACCINE
PATIENT INTAKE CONSENT FORM

VACCINE: *(CIRCLE ONE)* **PFIZER** **MODERNA** **DOSE #:** *(CIRCLE ONE)* **1** **2** **3**

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Gender: M ☐ F ☐
Last *First*

Mailing Address: _____
Street Address & Apt #

_____
City *State* *ZIP Code*

Phone: _____ Email: _____

Social Security #: _____ DL#: _____ State of Issuance: _____

Patient Race *(select one)*

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Black or African American
- ☐ White
- ☐ Other

Patient Ethnicity *(select one)*

- ☐ Hispanic
- ☐ Not Hispanic or Latino
- ☐ Unknown

(Select one for each)

Pregnant?
- ☐ Yes
- ☐ No

Employed in Healthcare?
- ☐ Yes
- ☐ No

Immunocompromised?
- ☐ Yes
- ☐ No

PRESCRIPTION INSURANCE

Prescription Benefit Plan Name: _____

Plan Information: _____
Cardholder ID# *Rx BIN* *PCN* *Group*

Medicare Part B Number (*if applicable*): _____

If uninsured, you must check the box below to attest that the following information is true and accurate:

I do not have health insurance, including but not limited to Medicare, Medicaid, or any other private or government-funded health benefit plan. ☐

In order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for Uninsured Patients, you must provide either (a) a valid Social Security number, (b) state identification number and state of issuance, OR (c) a driver's license number and the state of issuance.

SIGNATURE

I certify that my answers are true and complete to the best of my knowledge.

Signature: _____ Date: _____

Prtinted Name (*of person filing out form*): _____ Relationship: _____