COVID-19 Recipient Vaccination Questionnaire

PERSONAL AND CONTACT INFORMATION (*Please fill out ALL the information below)*

First Name:_____ **Last Name:**_____

Maiden Name:_____ **Social Security Number:**_____-_____-_____

Date of Birth_____/_____/_____
Month Day Year

Email:_____

Address: _____

City:_____ **County:** _____

State:_____ **Zip Code:** _____

Home Phone:_____ **Mobile Phone:** _____

Have you already registered in the COVID-19 Vaccine Portal? ☐ Yes ☐ No

DOSE INFORMATION

First Dose Manufacturer (Circle): Pfizer/ Moderna/ J&J **First Dose Date:** _____

Second Dose Manufacturer (Circle): Pfizer/ Moderna **Second Dose Date:** _____

COMMUNICATION PREFERENCE

☐ Email ☐ Text Message ☐ Both ☐ None

RACE

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian / Pacific Islander
☐ White
☐ Decline to answer

ETHNICITY

☐ Hispanic or Latino
☐ Not Hispanic or Latino

GENDER

☐ Male
☐ Female
☐ Decline to answer

DISABILITIES

☐ Not Disabled ☐ Cancer ☐ Cognitive (Psychological or Psychiatric)
☐ Neurological ☐ Physical (Mobility) ☐ Respiratory ☐ Sensory (Vision or Hearing)
☐ Other (Please Specify:_____)

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INSURANCE INFORMATION (Please fill out the information below)

(Circle all that apply) INSURANCE / MEDICAID / MEDICARE / NONE

Insurance Company Name:_____ Subscriber's ID (Policy Number):_____

Effective Date:_____ Group number: _____

Subscriber's Name (Policy Holder):_____ Subscribers Date of Birth: _____

Policy holder's employer:_____

Claims mailing address:_____ Benefits telephone number: _____

CONSENT

☒ I certify that I am either: (a) at least 18 years of age (b) legally able to consent to my own health care G.S. 90-21.5 (c) the parent or legal guardian of the minor patient; or (d) the legal guardian of the adult patient. Further, I hereby give my consent to the licensed healthcare provider administering the vaccine, as applicable (each an "applicable Provider"), to share my personal, demographic and health condition information in order to provide me with vaccination services for the COVID-19 vaccine. I understand that the health data shared within this questionnaire will be used to determine my eligibility for receiving the COVID-19 vaccination and further determine timing of when the vaccine will be made available to me.

☒ I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the risks and benefits of COVID 19 vaccine and request that the COVID19 vaccine be given to me or the person named above for whom I am authorized to make this request. I agree for Medicare, Medicaid and/or Insurance, if applicable, to be billed and I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to the Cabarrus Health Alliance.

☒ I have been provided access to the Cabarrus Health Alliance Notice of Privacy Practices.
https://www.cabarrushealth.org/DocumentCenter/View/347/Notice-of-Privacy-Practices

_____ _____

Signature of Recipient or Parent/Legal Guardian Date

_____ _____

Printed name of authorized representative Relationship to Patient

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FOR OFFICIAL USE ONLY

First Name:_____ **Last Name:**_____ **Date of Birth:**____/___/____
Month Day Year

**** Required Fields***

***Responsible Organization:** Cabarrus Health Alliance

"Responsible Organization" is the name of the parent organization or health system that originated and is accountable for the content of the record. If an organization has several clinics or facilities, this would be the organization that represents all of the clinics/facilities.

***Administration at Location:** Cabarrus Health Alliance **POD Site:**_____

"Administration at Location" is the name of the physical clinic or facility that reported the vaccination, refusal, or missed appointment. In a small practice setting, this could be the same as the responsible organization.

Site of Injection: ☐ Right Deltoid, IM ☐ Left Deltoid, IM ☐Other_____

Dose: ☐ First Dose ☐ Second Dose ☐ Additional Dose/Booster

Route: ☐ Intramuscular ☐ Subcutaneous ☐Intradermal

Administration Date:_____/_____/_____ Administration Time: _____

Vaccine Product: ☐ Moderna ☐ Pfizer (12+) ☐ Janssen ☐Pfizer (PEDS 5-11)

Moderna Dose Amount: ☐ Full Dose (0.50 mL) ☐ Half Dose (0.25 mL)

Lot #:_____ Exp:_____/_____/_____

Vaccine administered by (Clinician Name):_____ Signature_____

Notes:

_____
_____
_____
_____
_____
_____