2020-2021 Vaccine Insurance Information Form

The completion of this form is necessary for every vaccine recipient. If no insurance information is available, please fill out as much as possible using existing information (please print):

PATIENT INFORMATION Dose: ☐1st ☐2nd

Patient Name: Last | First | MI			
Date of birth:		Age	Sex: ☐ Male ☐Female
Street Address:			
City:	State:	Zip:	Phone: ☐Home ☐Cell phone ( )
EMAIL ADDRESS:			
Preferred Language other than English:			

☐ My Insurance Information ☐No Insurance

Name of Insurance Company:	Member ID Number:	Group ID Number: (if available)

If you are NOT the subscriber, please complete

Subscribers Name	Subscribers Date of Birth Month | Day | Year	Sex: ☐Male ☐Female

Subscribers Street Address (only if different from above)

Street City State Zip Phone

Relationship to patient ☐ Spouse ☐ Parent ☐Other

Emergency Contact Information

Name	Phone	Relationship to Patient

Demographics

Race	Ethnicity	
☐ **White** ☐**Black/African American** ☐**Native Hawaiian or Pacific Islander** ☐**Asian** ☐**Hispanic** ☐**Other** _____ ☐**American Indian/Alaskan Native** ☐ **Prefer to decline**	☐**Hispanic/Latino** ☐**Not Hispanic/Latino** ☐**Prefer to decline**	**Person being vaccinated identifies as having a disability(s)** □ **Yes** □ **No** □ **Prefer not to answer**

I give permission for my insurance company to be billed.

X _____ Date: _____

(Signature of patient, guardian)

********** DO NOT WRITE BELOW THIS LINE**********

Put in MIIS	Date of Service and VIS Given	Vaccine	Type of Vaccine*	Dose	Route (SC, IM)	Site (RA LA)	Vaccine Lot #	Vaccine Exp. Date	Vaccine Mfr.	Date on VIS
		COVID-19	COVID-19	.5ml	IM					N/A EUA

Vaccine Administrator: _____

Provider Name: Framingham Board of Health MDPH Provider PIN#: 10510

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Provider Address:150 Concord Street Framingham, MA 01702 (mail) 113 Concord Street Framingham, MA.01702 (clinic)

Screening Questions	***Yes***	***No***	***Don't Know***
1. Are you feeling sick today			
2. Have you received a dose of Covid-19 Vaccine □ Pfizer □ Moderner □ Johnson and Johnson □ Other: _____			
3. Have you ever had an allergic reaction to: *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen• or that caused you to go to the hospital It would also Include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, Including wheezing.)*			
• *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*			
• *Polysorbate*			
• *A previous dose of COVID-19 vaccine*			
4. Have you ever had an allergic reaction to another vaccine (other than COV1D-19 vaccine) or an injectable medication? (This would Include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen• or that caused you to go to the hospital. it would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, Including wheezing.)			
5. *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.*			
6. *Have you received any vaccine in the last 14 days?*			
7. *Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?*			
8. *Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?*			
9. *Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?*			
10. *Do you have a bleeding disorder or are you taking a blood thinner?*			
11. *Are you pregnant or breastfeeding?*			