Partnership Health Centers

COVID Vaccination Registration Form

Registrant Information

Name ______________________ DOB ______________

Address ______________________ Gender ______________

______________________ Race ______________

Phone ______________________ Ethnicity ______________

Email ______________________

Pre-Immunization Questionnaire

Yes	No	
☐	☐	Do you have any known or severe Allergic reaction to any vaccine?
☐	☐	Do you have any Bleeding Disorders or on Blood Thinners?
☐	☐	Does the person receiving the vaccine have a fever of ≥100 degrees F?
☐	☐	Did you receive Passive Antibody therapy in the past 90 days?
☐	☐	Are you considered an Immunocompromised patient?
☐	☐	Are you currently being treated for acute infection and on antibiotics?

Patient Signature ______________________

I have read, or have had explained to me, the CDC Emergency Use Authorization Form about the Johnson & Johnson Vaccine. I acknowledge that I have been given the opportunity to review the Ocean County Notice of Privacy Practices on this date. I understand that this vaccine may cause symptoms in some people but will not actually cause the COVID-19 Virus. I have had an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of the COVID-19 vaccine and request that the vaccine be given to me or for whom I am authorized to make this request. I have answered all questions truthfully and accurately. I authorize Partnership Health Centers to arrange billing of services to my insurance carrier. I authorize any holder of medical information about me to release to the insurance carrier of record and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature: ______________________ Date: ____________

Insurance Information

Medicare

Provider or Carrier Name

Provider or Member ID #

Group ID #

No out of pocket expense for vaccine, Insurance information is requested to help offset the cost of providing this service to you as the resident.

Vaccine Information

Dose	Manufacturer	Lot #	Expiration	Route
1st				Deltoid: ____ Left ____ Right

Signature of Nurse: ______________________ Date: ____________