Adult 18 and Over
COVID-19 Vaccination Intake Form

Please Print Legibly

Name: ____

Social Security # or Medicare # (Red/White/Blue Card): ________________________________

Date of Birth: ________________________ **Phone Number:** (_____) __________________

Address: ____

City / Address / Zip: ____

Email Address: ____

Name of Prescription Drug Insurance: ____

Rx Insurance ID: _____________________________ **Rx Group Number:** ________________

PCN Number: ______________________________ **Rx BIN Number:** ___________________

Subscriber's Name: ____

Subscriber's Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: ________________

Gender Listed on Insurance: ☐ Female ☐ Male ☐ Other

Race: ______________________________ **Ethnicity:** ________________________________

Any Health Conditions: ☐ No ☐ Yes, What: ______________________________________

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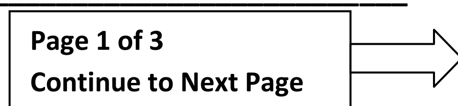

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FOR OFFICE USE ONLY - DO NOT WRITE BELOW THIS LINE

Date of Vaccination:		Injection Site
Individual Administering Vaccine		Left Arm / Right Arm
Vaccination Lot Number		

Age: _________

Vaccine Brand: ☐ Pfizer ☐ Moderna ☐ J & J ☐ Other: ______________

Vaccine #: ☐ 1st Dose ☐ 2nd Dose ☐ Booster Dose ☐ Other: ____________________

Pre-vaccination Checklist and Screening for COVID-19 Vaccines

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

QUESTION	YES	NO	UNKNOWN
1.) Are you feeling sick or ill today?			
2.) Have you ever received a dose of the COVID-19 Vaccine?			
If Yes, which one? ☐ Pfizer ☐ Moderna ☐ J&J ☐ Other ______________ Date ____________			
3.) Have you ever had a reaction to: (This would include a severe allergic reaction. {e.g. anaphylaxis} that required treatment w/epinephrine or EpiPen or that caused you to go to the hospital. Or reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing)			
A.) A Component of a COVID-19 Vaccine, Including either of the following?			
*Polyethylene glycol (PEG), which is found in some medications such as laxatives and preparations for colonoscopy procedures.			
*Polysorbate, which is found in some vaccines, film coated tablets and intravenous steroids.			
B.) A previous dose of COVID-19 Vaccine?			
C.) A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction			
4.) Has you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction. {e.g. anaphylaxis} that required treatment w/epinephrine or EpiPen or that caused you to go to the hospital. Or 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 vaccine? (This would include food, pet, venom, environmental or oral medication allergies).			
6.) Have you received any vaccine is the past 14 days? **If Yes,** which vaccine? ___________________________			
7.) Have you ever received a positive test for COVID-19, or has a doctor ever told you that you had COVID-19?			
8.) Have you ever 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 Organ Transplant or do you take immunosuppressive drugs or therapies?			
10.) Do you have a bleeding disorder or are you taking blood thinners?			
11.) Are you pregnant or breast feeding?			
12.) Do you have dermal fillers?			
Form Reviewed By:	**Date:**		

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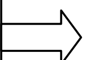

Patient Acknowledgement Form for COVID-19 Vaccination

I understand and agree to the following as part of my receiving the COVID-19 vaccine from Beacon Prescriptions:

* I agree and consent to receive the COVID-19 Vaccine myself and acknowledge that the risks, benefits and alternatives have been explained to my satisfaction. I understand the COVID-19 vaccine has the potential side effects. I understand there is a remote risk of more severe or unexpected side effects. I understand the use of the COVID-19 vaccine has been authorized by the US Food and Drug Administration (FDA) under the Emergency Use Authorization (EAU).

* There is no co-payment or out-of-pocket expense to me.

* Beacon Prescriptions has received the vaccine at no cost and will not submit any bills or invoices seeking payment for the vaccine itself, only the administration charge.

* I permit Beacon Prescriptions to bill my insurance and obtain payment for the administering of the vaccine to me, as well as reporting the vaccination to Connecticut Department of Public Health (CT DPH) Prescribed Wellness CT WIZ registry, under the following provisions.

Release of confidential information: I understand that my health care information is confidential and is protected from disclosure by law, but that it may be used for treatment, payment for services provided and healthcare operations. HIPAA/PHI Regulation allows for disclosure of this information between doctors, providers of services and insurance companies.

Release to the Insurer: I understand that Beacon Prescriptions and/or any physician entity or organization providing medical care or services may release information to my insurance carrier(s) or employees of the insurance company to substantiate payment for the administration costs incurred as a result of the COVID19 Vaccine administration and/or other medical services. Such persons or entities are permitted to obtain and examine necessary information from my medical records in accordance with applicable laws and the medical records policy of Beacon Prescriptions.

Assignment of Benefits: I assign benefits to be paid to Beacon Prescriptions for administration services provided to me for the COVID-19 Vaccinations. Payments including those from any government agency, insurance carrier or other financially responsible for the medical care rendered to me or my dependent.

Appeal: I agree that Beacon Prescriptions may appeal any denials of payment by my insurance company for medical services provided.

Provisions Specific to Individuals with Medicare and or Medicaid Insurance: I certify that the information I have provided for purposes of applying for payment under Title XVIII of the Social Security Act is accurate. I understand that any holder of my medical information regarding my treatment may release to the Social Security Administration and/or Centers for Medicare and Medicaid Services or its intermediaries or carriers any necessary information needed in relation to a Medicare/Medicaid claim. I request that payment of authorized benefits be made on my behalf and assign payment of those benefits to Beacon Prescriptions.

____ ____________________

Patient or Responsible Party Signature **Date**

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Responsible Party Relationship to Patient (If applicable)

Thank you!