Coquille Valley Hospital

940 East 5th Street, Coquille, Oregon 97423
Phone: 541-396-3101 | Fax 541-396-7374

COVID-19 Vaccine Demographic Form

Scan to: Conditions of Care

Patient's First Name	M.I.	Last Name	Birthdate	SSN
Address		City	State	Zip Code
Home Phone #	Cell Phone #	Employer	Marital Status	Sex
Email Address		Primary Care Physician		

Insurance Information

Insurance Company		Subscriber Name (First, Middle & Last)			
Insurance ID #		Group #	Employer	Home Phone #	
Subscriber DOB	Subscriber Sex	Address	City	State	Zip Code

Conditions of Care:

Authorization for treatment and hospital services - I authorize the doctor and others designated by such doctor to perform medical and /or surgical procedures and treatment at Coquille Valley Hospital and authorize the hospital to provide hospital services as authorized by such doctor or persons designated or appointed by such doctor.
Personal valuables and drugs – The hospital maintains safekeeping of money and valuables, and it is agreed that the hospital shall not be liable for the loss or damage to any money or other property, which has not been deposited, with the hospital for safekeeping. Patients are not permitted to have drugs in their possession, which have not been prescribed for use in the hospital.
Assignment of insurance benefits – The undersigned hereby assigns to Coquille Valley Hospital and authorizes direct payment to the hospital any insurance, Medicare or other benefits not to exceed the hospital's regular charges or hospital services.
Release of information – The hospital is authorized to release such information, including electronic health information, concerning this hospital service as may be necessary for the completion of insurance, Medicare or other claims for reimbursement. I authorize Coquille Valley Hospital to disclose (release) my results of this COVID-19 immunization to Oregon Vital Statistics as required by law.
Responsibility for hospital charges – In consideration of the hospital and medical services to the patient, the undersigned (whether patient, parent, or personal representative) agrees that all charges for hospital services will be paid upon presentment of a statement of charges or as otherwise agreed by the hospital. The undersigned also agrees that if the account is placed in the hands of any attorney, or other agency, for collection, the hospital will be entitled to reasonable fees.

The undersigned certifies that he/she has read the foregoing, and is the patient or is duly authorized by the patient as patient's agent to execute the above and accept terms.

Patient Signature: _____ Date: _____ Time: _____

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name _____

Date Of Birth _____

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today.

If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked.

If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Another product _____			
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 COVID-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?			

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists