ABBEVILLE AREA MEDICAL CENTER

Pfizer Vaccine:
☐ 1st dose
☐ 2nd dose
☐ Booster

PATIENT INFORMATION

Patient First Name: MI: Last Name:	Age:	Date of Birth:	Gender: ☐ Male ☐ Female
Ethnicity? ☐ Hispanic ☐ Not Hispanic ☐ Refused Marital Status? ☐ Single ☐ Married ☐ Widowed/Divorced	Language Spoken? ☐English ☐ Spanish ☐Other Race? ☐ White ☐ Asian ☐ Black ☐Hispanic ☐ Indian/Native ☐Other		
Mailing address:		Social Security #:	
City:	State:	Zip Code:	Home Phone: Cell Phone: Work Phone:
Email Address: ☐I do not have access to email		Family Doctor:	
Is the patient covered by insurance? ☐ Yes ☐ No	Is it Ok to leave a confidential voice mail; __Yes __ No Phone number that is OK to leave message; ______________		

Policy #:

Name on the insurance card?: ☐ SS # of the policy holder(required): ☐ Birth date of Policy ☐ Group #: ☐

☐ ☐ ☐ ☐ ☐ ☐

Patient's relationship to subscriber: ☐ Self(Medicaid) ☐ Child(covered under parent's insurance) ☐ Spouse ☐ Other

Consent for Services:

I have read or had explained to me the 2020-2021 Emergency Use Authorization (EUA) for the Covid-19 vaccine and understand the risks and benefits. Furthermore, I have had an opportunity to ask questions about these immunizations. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reaction that may result from either my receipt of the immunization(s) or the receipt of the immunization(s) by the person named below for whom I am the legal guardian (Ward). My medical record may be shared with my physician or other healthcare provider and the medical record of my Ward may be shared with his/her physician or other healthcare provider. I am requesting that the immunization(s) be given to me or my Ward. I, for myself and on behalf of my Ward, and each of our respective heirs, executors, personal representatives, and assigns, hereby release the provisioning mass vaccination center, and its affiliates, subsidiaries, divisions, directors, contractors, agents, and employees (collectively Released Parties), from any and all claims arising out of, in connection with or in any way related to my receipt and the receipt of my Ward of this or these immunization(s). Neither the provisioning mass vaccination center nor any of the Released Parties shall, at any time or to any extent whatsoever, be liable, responsible, or any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or by the administration of the vaccines described above. The provisioning vaccination center will use and disclose your personal and health information or the personal and health information of your ward, to treat you or your Ward, to receive payment of the care we provide, and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed Notice of Privacy Practices to help you better understand our policies in regard to you and your Ward's personal health information. ☐

I acknowledge that I have received a copy of the Notice of Privacy Practices.

Disclosure of Records:

I understand that Abbeville Area Medical Center (AAMC) may be required to or may voluntarily disclose my health information to my physician or other healthcare provider, my insurance plan. Health systems and hospitals, and/or state federal registries, for the purposes of treatment, payment, or other health care operations (such as administration or quality assurance). I also understand that AAMC will use and disclose my health information as set forth in the Notice of Privacy Practices and copy was given to me. I agree to have AAMC share my immunization data with Health Care Providers, agencies, or schools.

X____

Signature of patient to receive vaccine **Date**

Vaccine Administration Information for Immunizer/Pharmacist use Only

#1 ____________________ BioNTech Site: Right Deltoid or Left Deltoid IM
Administration Date Vaccine

Mfg #: Pfizer Lot #: ____________________ EXP. Date: ______________

______________________ ______________ ______________
Administering Immunizer Signature/Title Date Time

EHS 1062
10/11/2021