(760)-877-7761
www.760Smiles.com
1711 E Valley Parkway Suite #110 Escondido, CA 92027

FULL NAME_____ **DOB** _____**Sex**_____

ADDRESS & Phone #_____

Is this your first or second COVID 19 vaccination dose? First or Second.
If second, what was your first? (Pfizer, Moderna, or Other) _____ When? _____
Any severe reaction? _____

CONSENT FOR SERVICES: I have been provided with the COVID-19 Moderna Vaccine information sheet. I have read the information provided about the vaccine I am receiving and had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily request it. I assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: inform 760 Smiles, call your doctor, call 911. I request that the vaccine be given to me or the person named above for whom I am authorized to make this request.

SCREENING QUESTIONS for Potential Contraindications: (Please Circle Responses)

1. Do you feel sick today? **Yes. No. Don't Know.**
2. Have you ever had a severe reaction (e.g. Anaphylaxis) in the past? For example, a reaction that was treated with an EpiPen/Epinephrene, or required hospital care? **Yes. No. Don't Know.**

   I. Was the severe reaction after receiving a Covid 19 vaccine? **Yes. No. Don't Know.**
   II. Was the severe reaction after receiving another vaccine or injectable medication? **Yes. No. Don't Know.**
   III. Was the severe reaction related to receiving Polyethylene Glycol or products containing Polyethylene Glycol? **Yes. No. Don't Know.**
   IV. Was the severe reaction related to receiving Polysorbate Glycol or products containing Polysorbate? **Yes. No. Don't Know.**
3. Do you have allergies to latex? **Yes. No. Don't Know.**
4. Have you received any vaccines in the past 14 days? **Yes. No. Don't Know.**
5. Have you received any monoclonal antibodies or convalescent plasma as part of COVID-19 treatment in the past 90 days? **Yes. No. Don't Know.**
6. Do you have any autoimmune diseases such as cancer or HIV/AIDs? **Yes. No. Don't Know.**
7. Do you have a weakened immune system, or in the past 3 months, taken medications that weaken it such as radiation treatments? **Yes. No. Don't Know.**
8. Do you have a bleeding disorder or take any anticoagulation (blood thinner) medications? (For example, Warfarin or Coumadin) **Yes. No. Don't Know.**
9. Are you pregnant or breastfeeding? **Yes. No. Don't Know**

MEDICAL INSURANCE:_____/_____
Primary Cardholder's name/relation & DOB — Medical Insurance Name

_____/_____/_____/_____
Cardholder # — Group ID — Payer — Medicare Part A/B ID Number (MBI)

If UNINSURED: Please initial to attest that the following information is correct: I do NOT have any government or private medical insurance, including Medicare or Medicaid. _____ In order to have vaccine reimbursement payment from United States Health Resources & Services Administration's COVID-19 Program for Uninsured Patients, please provide either 1) valid social security number, 2) driver's license number and state of issuance, or 3) state identification card and state of issuance: _____/_____/_____
SSN — DL#/STATE — ID#/STATE

AUTHORIZATION TO REQUEST PAYMENT: I hereby authorize 760 Smiles to release information for payment reimbursement. I certify that the information provided is correct under Medicare, Medicaid, HRSA COVID-19 Program for Uninsured Patients, is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

DISCLOSURE OF RECORDS: I understand that 760 Smiles may need to disclose and report my immunization and related health information to other 760 Smiles staff, my insurance plan, health systems and/or hospitals, or county/state/federal registries for purposes of treatment, payment, or other health care operations (such as administration). I agree to have CAIR, if applicable, share my immunization data with health care providers, agencies, or schools as applicable.

PRINT NAME **SIGNATURE** **DATE**

If signing on behalf of recipient, you are certifying as an authorized representative or guardian. Please provide your name, relation, and Phone #.