WAIMĀNALO HEALTH CENTER

Patient Registration: ECV OUTREACH

PATIENT INFORMATION

Legal Last Name	First Name	M.I.	Preferred Name	Date of Birth

Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed

Do You Need An Interpreter? ☐ Yes ☐ No

Primary or Preferred Language: ☐ English ☐ Other: _____

Legal Sex (Please check one)* ☐ Male ☐ Female

*Sex assigned at birth (Male and Female). Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence.

Gender Identity
☐ Male
☐ Female
☐ Transgender Male/Female-to-Male
☐ Transgender Female/Male-to-Female
☐ Other
☐ Chose not to disclose

Sexual Orientation
☐ Lesbian, Gay or Homosexual
☐ Straight (not lesbian or gay)
☐ Bisexual
☐ Something else
☐ Don't know
☐ Chose not to disclose

Mailing Address	City	State	Zip Code

Please complete and indicate your preferred contact method by checking one of the boxes below:

☐ Home Phone	☐ Cell Phone	☐ Day Phone	☐ Email Address
( ) -	( ) -	( ) -	

Housing Status: ☐ Not Homeless ☐ Homeless: ☐ Doubling Up ☐ Shelter ☐ Street, Beach, Etc. ☐ Transitional ☐ Unreported

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Farmer Status: ☐ N/A ☐ Migrant ☐ Seasonal

Active Military or Veteran: ☐ Yes ☐ No

Race (pick one below that best describes you):

☐ African American/Black ☐ Caucasian ☐ Chinese ☐ Chuukese ☐ Filipino ☐ Guamanian
☐ Japanese ☐ Korean ☐ Laotian ☐ Marshallese ☐ Micronesian ☐ Native American
☐ Native Hawaiian ☐ Portuguese ☐ Puerto Rican ☐ Samoan ☐ Tongan ☐ Vietnamese
☐ Other Asian ☐ Other Pacific Islander ☐ All Other (please specify): _____

Employer:	Occupation:	Family Size (includes self, spouse, & children under 18): _____	Family Income: $ ☐ Monthly ☐ Annual

PARENT OR LEGAL GUARDIAN INFORMATION

Relationship of Guarantor to Patient (Check One): ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Legal Last Name	First Name	M.I.	Preferred Name	Date of Birth

Please complete and indicate your preferred contact method by checking one of the boxes below:

☐ Home Phone	☐ Cell Phone	☐ Day Phone	☐ Email Address
( ) -	( ) -	( ) -	

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:		Relationship:
Home Phone	**Work Phone**	**Cell Phone**

PRIMARY MEDICAL INSURANCE INFORMATION				
Patient's Relationship to the Insured (Check One): ☐ Self ☐ Spouse	☐ Parent ☐ Step-Child	☐ Child ☐ Other: _____		
Policy Holder Name	**Date of Birth**	☐ **Male** ☐ **Female** ☐ **Unknown**		
Plan Name	**Policy # / Subscriber #**	**Group #**	**Effective Date:**	**Expiration Date:**
Home Address	**City**	**State**	**Zip Code**	
Home Phone	**Work Phone**	**Cell Phone**		

_____ Initials

I hereby authorize WHC to release information to my insurance carrier in order to process claims on my behalf. I authorize payment of benefits to WHC for services rendered.

_____ Initials

I certify that the information I have furnished is true and correct to the best of my knowledge. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

_____ Initials

I understand that I can review a Notice of Privacy Practices upon request at the time of vaccination.

_____ _____

Patient Signature Date Signed Signature of Parent/Legal Guardian Date Signed

FOR OFFICE USE ONLY					
MEDICAL SERVICES – Record #_____					
Pt Status Type: ☐ Scheduled ☐ Inactive	☐ Non-WHC Active ☐ Dental Patient Only	**Valid ID:**	☐ ID Scanned ☐ NG Pt Picture Updated	**Insurance:**	☐ Card Scanned ☐ Info/Card Updated
Collected By: _____ Date: _____			Entered By: _____ Date: _____		

WAIMĀNALO HEALTH CENTER

Pre-vaccination Checklist for COVID-19 Vaccines

Patient Name:_____ **DOB**:_____ **Age:**_____

For vaccine recipients:

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 questions, 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.

Screening Questionnaire: please circle response below

1. Are you feeling sick today? *If Yes, please call back to schedule when the illness has improved. If patient has current COVID-19 infection, patient will need to call back after isolation is over.*	☐ **Yes**	☐ **No**	☐ **Don't know**
2. Have you ever received a dose of COVID-19 vaccine?	☐ **Yes**	☐ **No**	☐ **Don't know**
a. **If yes, which vaccine product? ☐Pfizer ☐Moderna ☐Janssen (Johnson & Johnson) Another product_____** b. **Where? _____ c. Date of vaccine? _____** *If yes and first dose was administered elsewhere, STOP and do not proceed. Vaccine series must be completed with prior vaccine site. If first dose was administered at WHC, ok to continue if same vaccine available at WHC.*			
3. Have you ever had an allergic reaction to (see list below): (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.) *If yes to any of the below, STOP and do not proceed. Vaccine is contraindicated.*			
a. **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**	☐ **Yes**	☐ **No**	☐ **Don't know**
b. **Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids**	☐ **Yes**	☐ **No**	☐ **Don't know**
c. **A previous dose of COVID-19 vaccine**	☐ **Yes**	☐ **No**	☐ **Don't know**
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 rection that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	☐ **Yes**	☐ **No**	☐ **Don't know**

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Pre-vaccination Checklist for COVID-19 Vaccines

If yes, inform patient he/she will be observed for 30 minutes after vaccination. If patient has questions, should be referred to Provider. **RN: counsel patients about unknown risks vs benefits of vaccination, refer patient to Provider if further discussion needed. Observe for 30 mins after vaccination.*			
5. Had COVID-19 and was treated with monoclonal antibodies or convalescent serum as a treatment for COVID-19? *If yes and at least 90 days since treatment, ok to schedule. Vaccination should be deferred for at least 90 days since treatment.*	☐ **Yes**	☐ **No**	☐ **Don't know**
6. Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection? *If yes, should refer patient to Provider prior to scheduling. Consider delaying vaccine until recovery from infection and 90 days after date of diagnosis.*	☐ **Yes**	☐ **No**	☐ **Don't know**
7. Check all that apply to you: ☐ **Am a female between ages 18 and 49 years old** ☐ **Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies** *(30 min observation)* ☐ **Have a weakened immune system (i.e., HIV infection, cancer)** ☐ **Take immunosuppressive drugs or therapies** ☐ **Have a bleeding disorder** ☐ **Take a blood thinner** ☐ **Have a history of heparin-induced thrombocytopenia (HIT)** ☐ **Am currently pregnant of breastfeeding** ☐ **Have received dermal fillers**	☐ **Yes**	☐ **No**	☐ **Don't know**

I, the undersigned, have read the Emergency Use Authorization for the COVID-19 Vaccination. I understand the risks and benefits associated with the COVID-19 vaccine and have had any questions satisfactorily answered. I voluntarily request that the vaccine be given to me.

Signature:_____ **Date**:_____

For Office Use Only:

Date/time given: _____

Vaccine Name/Lot #/Expiration/Dose/Route: **Place Sticker Here*
Vaccine Dose: 1 2 Site: RD LD

From reviewed/Administered by:_____ Observed for 15 minutes/30 minutes. Pt Initials:_____