orchidhealth
*Exceptional, local healthcare*

## COVID Vaccine Form - New Patient

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

**Address:**_____**City**_____**State/Zip**_____

**Phone:**_____ **Email** _____

**Gender: Male Female Other**

**Insurance Company**_____**ID** _____**Group**_____

**Insurance Phone Number**_____ **Insurance Address** _____

**Primary Care Provider:**_____

**Please list any ALLERGIES you have to medications:**

NAME OF MED: Reaction:

_____

_____

_____

**Please list any MEDICATIONS that you currently take, including Over the Counter Medications, Herbal Supplements, or Vitamins:**

NAME OF MED Dose Directions (How often you take it)

_____

_____

_____

_____

_____

**Please list any known medical diagnoses that you have (i.e. Diabetes/High Blood Pressure, Asthma, etc etc)**

_____

_____

_____

**General Health:** ❒ excellent ❒ good ❒ fair ❒ poor

Are you sick or do you have a high fever today? Yes No

If yes, what symptoms do you have?

**Mark all that apply:** ❒ fever or chills ❒ cough ❒ shortness of breath ❒ sore throat ❒ fatigue ❒ headache ❒ muscle aches ❒ loss of taste or smell ❒ congestion or runny nose ❒ nausea or vomiting ❒ diarrhea ❒ other

**I acknowledge that:**

1. I am at least 18 years of age. I have read or had explained to me COVID Vaccine information sheet. I have been given the opportunity to ask an Orchid Health healthcare professional questions concerning the COVID vaccination. All of my questions concerning COVID vaccination have been answered to my satisfaction.
2. I understand that Orchid Health will submit this vaccine information to the state vaccine registry for public health tracking.
3. **Authorization of Payment:** I assign and authorize direct payment to Orchid Health of all insurance and plan benefits that are payable for service(s) I receive and also authorize release of any medical records necessary to facilitate my treatment to process claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.
4. **Notice of Privacy Practices:** I acknowledge receipt of Orchid Health's Notice of Privacy Practices. This notice is provided the first time I receive services from Orchid Health and is otherwise available to me at any time upon request.

**Release of Liability:**

I have read and I understand the acknowledgements set forth above, and I hereby release Orchid Oakridge Clinic, PC and their affiliated entities, and all of their agents, employees, owners, and representatives, from any and all liability which may arise from COVID vaccine and/or from the information provided to me concerning such COVID vaccine.

_____ _____

Patient Signature Date

If signed by someone other than recipient, please indicate name and relationship: _____

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COVID swab performed by: _____ Date: _____ _____