Mid Coast Health System

Name:	Sex: **M F**	DOB:	Phone:
Address:	City:	State:	Zip Code:
County:	Ethnicity: Hispanic Non-Hispanic Prefer not to disclose		
Race: American Indian or Alaska Native Asian African American or Black Native Hawaiian or Other Pacific Islander White Other Prefer not to disclose			

Insurance Company:	Address:	
City:	State:	Zip:
Phone:	Name of Insured:	
SSN:	Relationship to Patient:	
Policy ID Number:	Group Number:	

Do you have or have you had any of the following: (CIRCLE ONE) **YES** **NO**

Cancer	Chronic Kidney Disease
Down Syndrome	Organ Transplantation
Pregnancy	Sickle Cell Disease
Diabetes Mellitus	HIV
Smoking	Autoimmune disease
Liver Disease	Pulmonary Fibrosis
Neurological conditions (including dementia)	
COPD (Chronic Obstructive Pulmonary Disease, including Asthma)	
Obesity, severe obesity, and morbid obesity	
Heart Conditions: Congestive Heart Failure, Coronary Artery Disease, Stroke or cardiomyopathies	

Have you had any of the following:

History of severe reaction to any vaccine or medication that required medical attention in the past?	**YES**	**NO**
High fever of severe illness in the past 7 days?	**YES**	**NO**
Have you received any other vaccinations in the past 14 days?	**YES**	**NO**
Have you had SARS CoV 2 (COVID) and are you in the quarantine time period?	**YES**	**NO**
Have you received convalescent plasma for SARS CoV 2 (COVID) in the last 90 days?	**YES**	**NO**

By Signing the Consent, I understand that I agree to:

* receive the COVID-19 Vaccine and obtain further doses as required. administered.
* confidentially report any significant adverse reaction to the facility administering your vaccine or your provider.
  continue safety practices such as wearing a face mask, social distancing, and frequent hand-washing.

*** I understand that protection against COVID-19 may not be effective until at least 7 days after the second dose.**

*ASSIGNMENT OF BENEFITS-Hospital-Physicians: I/We hereby transfer, assign and convey all my/our rights, title and interest in all benefits due to me/us, If any, by reason of services, described in the statements rendered, and as provided for in any contract or policy of insurance under which I/we may be an insured of beneficiary and I direct said insurance company to pay directly to El Campo Memorial Hospital at El Campo, TX all such benefits.
*MEDICARE ASSIGNMENT AND AUTHORIZATION: I certify that the information given by me in applying for payment under Title XVVII of the Social Security Act is correct. I request that the payment of authorized benefits be made on my behalf.

Signature _______________ Date _______________

Mid Coast Health System

Nombre	Sex: **M F**	Fecha de nacimiento:	Teléfono:
Dirección:	Ciudad:	Estado:	Código postal:
Condado:	Ethnicity: Hispanic Non-Hispanic Prefer not to disclose		
Race: American Indian or Alaska Native Asian African American or Black Native Hawaiian or Other Pacific Islander White Other Prefer not to disclose			
Compañía de seguro: Dirección:			
Ciudad:	Estado:	Código postal:	
Teléfono:	Nombre del asegurado:		
Número de seguridad social:	Relacion al Paciente:		
Número de identificación de la póliza: Numero de grupo:			

¿Tiene o ha tenido alguno de los siguientes: (CIRCLE)

Cáncer	VIH
Enfermedad renal crónica	Fumar
Síndrome de Down	Enfermedad autoinmune
Transplante de organo	Enfermedad del higado
Embarazada	Fibrosis pulmonar
Anemia drepanocítica	Condiciones neurológicas (incluida la demencia)
Diabetes mellitus	
Obesidad, obesidad severa y obesidad mórbida	
Condiciones cardíacas	

Have you had any of the following:

¿Historial de reacción grave a alguna vacuna o medicamento que requirió atención médica en el pasado?	**SI**	**NO**
¿Fiebre alta de una enfermedad grave en los últimos 7 días?	**SI**	**NO**
¿Ha recibido alguna otra vacuna en los últimos 14 días?	**SI**	**NO**
¿Ha tenido SARS CoV 2 (COVID) y se encuentra en el período de cuarentena?	**SI**	**NO**
Have you received convalescent plasma for SARS CoV 2 (COVID) in the last 90 days?	**SI**	**NO**

Al firmar el consentimiento, entiendo que acepto:

* recibir la vacuna COVID-19 y obtener dosis adicionales según sea necesario.
* informar de manera confidencial cualquier reacción adversa significativa al centro que administra su vacuna oa su
* Continuar con las prácticas de seguridad, como el uso de una mascarilla, el distanciamiento social y el lavado
* **Entiendo que la protección contra COVID-19 puede no ser efectiva hasta al menos 7 días después de la segunda dosis**
* CESIÓN DE BENEFICIOS-Hospitales-Médicos: Por la presente transferimos, cedemos y transmitimos todos mis /
* ASIGNACIÓN Y AUTORIZACIÓN DE MEDICARE: Certifico que la información proporcionada por mí al solicitar el pago

Firma   Fecha

Manufacturer   **Lot #**   **Site**

Dose: 1 2