PATIENT INFORMATION

CONFIDENTIAL

(PLEASE PRINT CLEARLY)

LAST NAME _____FIRST NAME_____ MI____ BIRTHDATE_____ ❒ M or ❒ F

SS #_____-_____-_____ CHECK ONE: ❒ Minor ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

ADDRESS_____CITY_____ST_____ZIP _____

HOME PHONE ( )_____ CELL # ( )_____ WORK # ( ) _____

e-MAIL _____ OCCUPATION: _____

PATIENT'S EMPLOYER_____ Full-Time / Part-Time / Retired

SPOUSE OR PARENT'S NAME_____

EMPLOYER_____ WORK PHONE ( ) _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____CITY_____ST____ ZIP _____

HOW DID YOU HEAR ABOUT THIS CLINIC?
❒ Friend/Family ❒ Telephone Book ❒ Newspaper Ad ❒ Internet ❒ Referred by Dr. _____ ❒ Other _____

EMERGENCY CONTACT

NAME_____ PHONE ( ) _____ RELATIONSHIP PATIENT _____

ADDRESS _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____RELATIONSHIP PATIENT _____

DOB: _____ SS #_____-_____-_____ HOME PHONE ( )_____CELL # ( ) _____

ADDRESS, CITY, ST, ZIP _____

EMPLOYER _____WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? Yes or No

INSURANCE INFORMATION

Please bring your Photo ID and Insurance Card(s) for your appointment.

We will scan your ID and insurance information in to your chart:
We are located at:

MYRNA C. DE ASIS, M.D.
1819 10TH ST
WICHITA FALLS, TX 76301
TEL (940) 763-8077
FAX (940) 763-8078
www.DeAsisMD.com

ALL SERVICES ARE PAYABLE IN FULL UNLESS ARRANGEMENTS ARE MADE IN ADVANCE.

I authorize release of any information concerning my (or my child's) health care, advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to Dr. De Asis. I fully understand that whatever my insurance does not cover or pay, I am responsible for the payment of the medical service/procedure. I hereby permit Dr. De Asis to render medical/surgical treatments to the above named patient. Dr. De Asis does not guarantee any treatment outcome or cures.

_____ _____
Signature of patient or parent if minor Date

Pre-Vaccination Checklist for COVID-19 Vaccines

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 question, 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.

Patient Name _____

Age _____

Date of Birth _____

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ Another product _____			
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?			
• Was the severe allergic reaction after receiving a COVID-19 vaccine?			
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?			
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
5. Have you received another vaccine in the last 14 days?			
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
8. Do you have a bleeding disorder or are you taking a blood thinner?			
9. Are you pregnant or breastfeeding?			

Please continue to the back page.

Form reviewed by _____ **Date** _____

	Yes	No	Don't Know
10. Have you had a COVID-19 infection in the last 30 days?			
11. Have you had close contact with a COVID-19 positive person in the last 14 days?			

I have read, or given the information about the disease and vaccine listed below:

FACT SHEET FOR RECIPIENTS AND CAREGIVERS
EMERGENCY USE AUTHORIZATION (EUA) OF
THE MODERNA COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019
(COVID-19) IN INDIVIDUALS 18 YEARS OF AGE AND OLDER

I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine cited and ask the vaccine below be given to me or to the person named above (for whom I am authorized to make this request.) I understand that it is recommended I stay on location for 15 minutes following the injection.

X_____ Date_____
Signature of person to receive vaccine (or person authorized to make the request)

For Clinic Use Only

COVID-19 VACCINE	Manufacturer: MODERNA	GTIN 00380777273990 Lot 027L20A Exp. 12/31/2069	Date Given	Site L / R Deltoid	Initials	EHR	