Date: ________________

MR#: ________________

www.semrhi.com

Patient Registration Information

(Please Print)

Do you need assistance completing your paperwork? ❒ Yes ❒ No

Patient Name: ____

(Last) *(First)* *(Middle)*

Social Security #:__________________ **Date of Birth:** ___________ **Birth Sex**: ❒Male ❒ Female

Patients by Gender Identity: ❒Male ❒Female ❒Gender queer ❒Transgender Male/Female-to-Male ❒Transgender Female/Male-to-Female ❒Choose not to disclose ❒Other ________

Patients by Sexual Orientation: ❒Lesbian or Gay ❒Straight or Heterosexual ❒Bisexual ❒Something else ❒Don't Know ❒Choose not to disclose

Address: ____

P.O. Box/ Street Address *City* *State* *Zip* *County*

Home Phone: ______________ **Cell Number**: ____________**email address**: ________________________

Patient Language: ❒English ❒Spanish ❒Vietnamese ❒French ❒Creole ❒Arabic ❒Other __________

Interpreter Needed: ❒Yes ❒ No **Hearing Impaired:** ❒Yes ❒ No **Visually Impaired:** ❒Yes ❒ No

Are you: ❒ Married ❒Single ❒ Widowed ❒ Divorced

Religion: ❒Baptist ❒Catholic ❒Jehovah Witness ❒Methodist ❒Muslim ❒Presbyterian ❒Other____________

Patient Ethnicity: Are you Hispanic or Latino Descent? ❒ Yes ❒ No

Patient Race: *(Check all that apply)* ❒American Indian/Alaska Native ❒Asian ❒Black/African American ❒Native Hawaiian ❒White/Caucasian ❒Other Pacific Islander ❒Unreported/Refused to report

Patient Veteran Status: Are you a veteran? *(Served in the United States Military)*❒ Yes ❒ No

Are you Homeless:❒Yes ❒No *(If yes, please choose one)* ❒Shelter ❒Doubling Up ❒Street ❒Other ❒Unknown

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PRIMARY CARE PROVIDER:

Who do you consider to be your Primary Care Provider (PCP)? ________________________________

Address ____________________________ City ______________________ State_______ Zip ______________

EMERGENCY CONTACT: __________________________ **RELATIONSHIP TO PATIENT:** ______________

Emergency Contact Phone#: ____________________________ **Cell #:** ________________________________

EMPLOYMENT:
Are you currently: ❒Employed ❒Unemployed ❒ Student ❒Disabled ❒Retired **Status:** ❒Full Time ❒Part Time

If Employed, where: ____

Address of Employer: ______________________________ **Emp. Phone #:**________________
P.O. Box / Street Address *City / State*

Responsible Party's Name: ______________________________ Social Security #**:**______________________

Address: ____
P.O. Box/ Street Address *City* *State* *Zip* *County*

Home Phone: ________________ Cell Number: _____________email address: ____________________________

Responsible Party's Emp.: _________________________________Emp. Phone #**:** _________________________

This Clinic has special payment provisions for person who need health care but who are without means of paying for services. Such persons must qualify for assistance by way of an approved Application for Adjusted Fee.

How many people live in your household? ______ ❒ Refuse to Report

What is your annual household income? ❒$5,000 or less ❒ $5,001 - $10,000 ❒ $10,001 - $15,000
❒ $15,001 - $25,000 ❒$25,001 - $50,000 ❒$50,001 - $ 75,000 ❒ $75,001 - $100,000❒over $100,000

Do you have Medical Insurance? ❒Yes ❒ No

If yes,
Insurance Co. Name: _________________________
Insured's Name: ______________________________
Relationship to Patient: ________________________
Insured's Soc. Security #: _______________________
Subscriber's DOB: ____________________________
Contract #: _____________ Group #: ___________

Second Insurance Co. Name: ______________________
Insured's Name: _________________________________
Relationship to Patient: ____________________________
Insured's Soc. Security #: ___________________________
Subscriber's DOB: _________________________________
Contract #: _______________ Group #: ________________

Medicare #: __________________________________ Medicaid #: ____

Do you currently have an advanced directive or durable power of attorney for healthcare? □ Yes □ No
If not, would you be interested in talking with Social Services about one? □ Yes □No

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AUTHORIZATION FOR MEDICAL CARE:
Permission is hereby granted for medical care, as may be advisable or necessary by the attending healthcare provider of this Health Center.
I understand that the Health Center will NOT be responsible for hospitalization charges, nor will it be responsible for other services unless specifically authorized.

I have read and understand the above consent and accept its terms.

____________________________________ ________________________________
Signature of Patient/Parent/Guardian Signature of Witness

SeMRHI
Southeast Mississippi Rural Health Initiative, Inc.
A Network of Community Health Centers
Hattiesburg - Seminary - Brooklyn - Lumberton - Sumrall - New Augusta - Beaumont - Picayune
Administration
5488 US Highway 49/ P.O. Box 1729 Hattiesburg, MS 39401
Office: 601-545-8700 Fax: 601-582-5461 www.semrhi.com

COVID-19 VACCINATION CONSENT - Moderna

Please Complete All Information Below-Please Print

Name____ID# ________________Dept ______________

SS#______________________DOB___________Age_______Race _________Sex: F___ M ___

Address ____

City _______________________________County ___________________St_______ Zip _____________

1. You should not get the COVID-19 Vaccine if you:
   - had a severe allergic reaction after a previous dose of this vaccine
   - had a severe allergic reaction to any ingredient of this vaccine.
2. WHAT ARE THE INGREDIENTS IN THE COVID-19 VACCINE?
   - The **Moderna** COVID-19 Vaccine includes the following ingredients: 100 mcg of nucleoside-modified messenger RNA (mRNA) encoding the pre-fusion stabilized Spike glycoprotein (S) of SARS-CoV-2 virus, total lipid content of 1.93 mg (SM-102, polyethylene glycol [PEG] 2000 dimyristoyl glycerol [DMG], cholesterol, and 1,2-distearoyl-sn-glycero-3-phosphocholine [DSPC]), 0.31 mg tromethamine, 1.18 mg tromethamine hydrochloride, 0.043 mg acetic acid, 0.12 mg sodium acetate, and 43.5 mg sucrose.
3. Tell the vaccination provider about all of your medical conditions, including if you:
   - have any allergies
   - have a fever
   - have a bleeding disorder or are on a blood thinner
   - are immunocompromised or are on a medicine that affects your immune system
   - have received another COVID-19 vaccine
4. Are you now currently ill and/or fever? ☐Yes ☐No
5. Are you pregnant or plan to become pregnant? ☐Yes ☐No
   - Clinical trials for the vaccine have not included pregnant women as of December 2020. Please consult with your provider if you are pregnant or breastfeeding.

SeMRHI COVID-19 VACCINE INFORMED CONSENT:
I have read or it has been explained to me the information about the COVID-19 vaccine and its approval via the emergency use authorization. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of COVID-19 vaccine and request the vaccine be given to me. Therefore, I agree to hold SeMRHI harmless from any injury, complication or side effect(s) caused by the administration of said vaccine.

Vaccine	Date Dose Administered	Injection Site	Vaccine Manufacturer	Lot Number	Signature of Vaccine Administrator	EUA
2020 - 2021 COVID-19 Vaccine		☐Left ☐Arm ☐Right ☐Thigh	Moderna			December 2020

____ ________________

Patient's Signature Date

____ ________________

Witness (Signature) Date

(1/2021)

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name ______________________

Age ________

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.

	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 did you receive? ☐ Pfizer ☐ Moderna ☐ Another product ______			
3. Have you ever had an allergic reaction to: (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.)			
• 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			
• Polysorbate			
• A previous dose of COVID-19 vaccine			
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 reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			

Form reviewed by ______________________ **Date** ____________

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists

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