Behavioral Health Network, Inc.
COVID Immunization Intake Form

Name: _____ **Age:** _____ **Date of Birth:** _____

Best Phone # to reach you at: _____ **Appointment Time:** _____

I authorize the release of any medical information with respect to this vaccine to my healthcare providers including third party payers as needed for payment benefits. **YES** **NO**

I am aware of the requirement to be monitored for at least 15 minutes following administration of this vaccine. **YES** **NO**

BHN is offering the COVID-19 vaccine. The vaccine is being offered on a voluntary basis. I consent to having the vaccination administered. I fully discharge Behavioral Health Network Inc. its affiliates, directors, and employees from any liability for illness, injury, loss, or damage which may result there from. **YES** **NO**

Signature:_____**Date**:_____

Do you have a Primary Care Provider? Yes No

Do you give BHN premission to share your vaccination status **Yes** **No**

Primary Language/ Lenguaje Primaria: _____

Country of Birth/Pais de nacimiento: _____

Race/ Raza (Please check one/ Marque uno):
☐ American Indian/Native Alaskan Indio Americano / Nativo de Alaska
☐ Asian/ Asiático
☐ Black/African American Negro / Afroamericano
☐ Native Hawaiian/Other Pacific Islander Nativo Hawaiian / Otra Isla del Pacífico
☐ White/ Blanco
☐ Other/ Otro
☐ Don't Know/ No lo se
☐ Declined/ Rechazado

Insurance Status/seguro:
☐MassHealth/Medicaid
☐Medicare
☐ Medicaid/Medicare
☐ NoInsurance
☐ Health Safety Net
☐ Private Insurance
☐ Other
☐ Declined

Ethnicity/ Etnicidad (please circle one/ Marque con un círculo):
☐ Non-Hispanic or Latino/ No Hispano o Latino
☐ Hispanic/ Hispano
☐ Other/ Otro
☐ Declined/ Rechazado

CLINIC SITE: _____

---***BELOW FOR OFFICE USE ONLY***---

Vaccine Received: _____ **Administered by**: _____

Confirmed Entry into MIIS: ☐
Check and balance completed: ☐
Billing/Diagnosis Completed: ☐
CVA Form Completed ☐

Date of 1st Dose:_____
Date of 2nd Dose:_____
Date of 3rd Dose:_____
Zip Code:_____ Male or Female