Psquared Medicals Inc.
4809 Argonne ST Ste. 155
Denver CO 80249

COVID Vaccine Outreach Clinic Patient Registration Form

For office use:	
	Registered
	Charted

PATIENT INFORMATION AND DEMOGRAPHICS

Last Name:_____ **Date of Birth:** ____ /____/ ____
Month Date Year

First Name: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other:_____

Patient's Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Other

Phone Number: _____-_____-_____

Street Address:_____ **Apt:**_____

City:_____ **State:**_____ **Zip Code:** _____

Ethnicity (select all that apply): ☐ White ☐ Hispanic ☐ Black ☐ Asian ☐ Filipino ☐ Pacific Islander ☐ American Indian ☐ Alaskan Native ☐ Other:_____

Emergency Contact: _____

Relationship:_____ **Phone Number:**_____-_____-_____

COVID VACCINE ELIGIBILITY CRITERIA:

☐ 50 years of age or older
☐ Healthcare Worker or First Responder
☐ 1+ High Risk Conditions Pre-
☐ K-12 Educator, childcare
☐ Frontline essential worker
☐ Other: _____

HEALTH INSURANCE? ☐ Yes ☐ No

Health Insurance Company: _____

Subscriber Name: _____

Group Number: _ **Policy/ID Number:** _

HEALTH QUESTIONNAIRE (Please select yes or no):

☐ Yes ☐ No Are you immunocompromised?
☐ Yes ☐ No Have you ever had a severe allergi reaction?
☐ Yes ☐ No Are you pregnant?
☐ Yes ☐ No Are you breastfeeding?
☐ Yes ☐ No Have you had a vaccine other thar COVID in the past two weeks?

Consent to receive vaccine: I have been offered a Vaccine Information Statement. I have read or had explained to me the information on the Vaccine Information Statement about COVID-19 and the COVID-19 vaccine. I have had a chance to ask questions which were answered to my satisfaction. I understand the risks and benefits of the COVID-19 vaccine, and request that the vaccine be given to me.

Signature:

PROVIDER DOCUMENTATION				
COVID Dose 1	R	L	Vaccinator:	Time of Vaccine: