Texas Allergy Center
Jane J. Lee, M.D., P.A.
Board Certified in Allergy, Asthma, and Immunology
Board Certified in Internal Medicine

Patient: ____ SS Number: ____________________
Last First MI

Sex: ( ) M ( ) F Age: ____ DOB: _______ Marital Status: ( ) M ( ) D ( ) S ( ) W

Home Address: ____
City State Zip Code

Electronic Mail Address: ____

Home Phone: ______________ Cell Phone: ______________

Employer: ___________________________________ Work Phone: ____________________

Work Address: ____
City State Zip Code

PRIMARY INSURANCE INFORMATION

Name of Insured: ______________________________ Relationship to Patient:______________

DOB: ________SS#: _________________Employer:___________________________________

Insurance Company: _________________________________ ID#: _______________________

Group#: ___________________ Benefit Verification Phone#: ___________________________

SECONDARY INSURANCE INFORMATION

Name of Insured: ______________________________ Relationship to Patient:______________

DOB: ________SS#: _________________Employer:___________________________________

Insurance Company: ____________________________________ ID#: ____________________

Group#: ___________________ Benefit Verification Phone#: ___________________________

In Case of Emergency, Notify: ____
Relationship: ________________________
Work Phone: _____________________________ Cell Phone: ___________________________

RELEASE OF INFORMATION: I hereby authorize the physician and/or supplier to release any information required to process this claim and claims for any future treatment unless rescinded by me in writing.

Date: __________________ Signature: X ____

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to Jane J. Lee, M.D., P.A. for services performed. I also understand that any and all services (including allergy extract) that are not covered by the insurance will by my responsibility.

Date: ___________________ Signature: X ____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: ____
(please print)

Date of Birth: __________________________

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

I request that all communications to me (by telephone, mail, electronic mail or otherwise) by Jane J. Lee, M.D. and staff are handled as follows:

- For WRITTEN Communication Address to:

____

____

- For ORAL Communication Call: ___________________________________
(Home Phone)

May we leave a message? ___________________________________
☐ Yes ☐ No (Cell Phone/Work Phone)

- Electronic Mail Communication Address to:___________________________
(E-mail address)

If the address above is not your home address OR is not a street address, please provide us with a street address for purposes of ensuring payment:

____

____

- I wish to place the following restrictions on disclosure of my health information:

____

Patient (Guardian) Signature: X__________________________Date:__________

Relationship to Patient: ___________________________

Practice: ☐ Accepts ☐ Denies
Privacy Officer Signature: ___________________________Date: __________

TEXAS ALLERGY CENTER

411 NORTH WASHINGTON AVE
SUITE 2400
DALLAS TX 75246
214-370-5700

VACCINATION CONSENT FORM

Pfizer-BioNTech COVID-19 Vaccine

The novel coronarvirus SARS-CoV-2 (a/k/a COVID-19) is an infectious disease that appeared in late 2019. The Pfizer-BioNTech COVID-19 Vaccine is an unapproved vaccine that may prevent COVID-19. There is no FDA-approved vaccine to prevent COVID-19 at this time.

I request that the Pfizer-BioNTech COVID-19 Vaccine be given to me or to the person named hereafter for whom I am authorized to make this request (select one): ☐ MYSELF ☐ PERSON NAMED BELOW

Recipient's Information:

__________ Last Name __________ First Name __________ Date of Birth ______ Gender

Address:____________________
City:__________ State:__________ Zip:__________

Authorized Individual's Information (complete if different from vaccine recipient):

__________ Last Name __________ First Name __________ Date of Birth ______ Gender

Address:____________________
City:__________ State:__________ Zip:__________

Relationship to recipient:____________________

Vaccine is for (check one): ☐ Physician ☐ Contractor ☐ Employee ☐ Volunteer ☐ Other:__________

Company/Organization:____________________

ACKNOWLEDGEMENTS (INITIAL EACH STATEMENT):

______ Prior to vaccination, I was given a copy of the FDA's *Fact Sheet for Recipients and Caregivers* in connection with the Emergency Use Authorization (EUA) for the Pfizer-BioNTech COVID-19 Vaccine or was directed to the FDA's COVID-19 vaccination website at: Pfizer-BioNTech COVID-19 Vaccine | cvdvaccine.com.

______ The recipient or their caregiver has the option to accept or refuse Pfizer-BioNTech COVID-19 Vaccine.

______ The significant known and potential risks and benefits of Pfizer-BioNTech COVID-19 Vaccine, and the extent to which such risks and benefits are unknown, have been disclosed to me. Information about available alternative vaccines and the risks and benefits of those alternatives, to the extent reasonably known, have been disclosed to me.

______ The Pfizer-BioNTech COVID-19 Vaccine is administered intramuscularly as a series of two doses 3 weeks apart. Recipients must receive both doses of the Pfizer-BioNTech COVID-19 Vaccine to complete vaccination.

______ Recipient is 5 years of age or older.

______ Immunocompromised persons, including individuals receiving immunosuppressant therapy, may have a diminished immune response to the Pfizer-BioNTech COVID-19 Vaccine.

______ Vaccine may not protect all vaccine recipients.

_______ The Pfizer-BioNTech COVID-19 Vaccine includes the following ingredients: mRNA, lipids ((4-hydroxybutyl)azanediyl)bis(hexane-6,1-diyl)bis(2-hexyldecanoate), 2 [(polyethylene glycol)-2000]-N,N-ditetradecylacetamide, 1,2-Distearoyl-sn-glycero-3- phosphocholine, and cholesterol), potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, and sucrose.

_______ I have read or have had explained to me the information identified in the FDA's *Fact Sheet for Recipients and Caregivers* regarding the Pfizer-BioNTech COVID-19 Vaccine. I have had an opportunity to discuss the benefits and risks of this COVID-19 vaccine with a healthcare provider of my choice before vaccination. I have had a chance to ask questions which were answered to my satisfaction.

_______ I believe I understand the benefits and risks of this vaccine and ask that this vaccine be given to me or the person named for whom I am authorized to make this request.

MEDICAL SCREENING QUESTIONS: Check yes or no to each question below. Tell your vaccination provider about all your medical conditions, including if you answer "yes" to any question. Except for the last two (2) questions, a "yes" response to any other question means you may wish to consult with your individual healthcare provider before proceeding. Answering "yes" to either of the last two (2) questions means you should not be vaccinated today.

Question	Yes	No
Do you have any allergies?		
Do you have a fever?		
Do you have a bleeding disorder or are on a blood thinner?		
Are you immunocompromised or are you on a medicine that affects your immune system?		
Are you pregnant or plan to become pregnant?		
Are you breastfeeding?		
Have you received another COVID-19 vaccine?		
Have you had a severe allergic reaction after a previous dose of this vaccine?		
Have you had a severe allergic reaction to any ingredient of this vaccine?		

X ____ ______________

Signature of Recipient OR Recipient's Authorized Individual **Date**

DO NOT WRITE IN THIS SPACE—OFFICE USE ONLY VIS Edition Provided: ______________

Vaccine:______________________ Administration Date:______________

Manufacturer:______________________ Lot #:______________

Exp. Date:______________ Route:______________

Site:______________ Volume (ml):______________

____

Nurse/ Provider's Signature Date Time