PICMED OF OKLAHOMA
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Drug Testing • Corporate Wellness • Flu Shots • Clinical Lab Services • D.O.T. Physicals • Vaccinations • DNA Testing • On-Site Employer Services

**B-12**

# B-12 Consent Form

## Patient Information and Consent

***PLEASE PRINT CLEARLY***

| | | | | | |
|---|---|---|---|---|---|
| Last Name: * | | First Name: * | | Middle Initial: * | |
| Address: | | | | | |
| Zip: | | City, State: | | | |
| Home Phone: | | Cell Phone: | | Work Phone: | |
| Employer: | | | | | |
| Birth Date: * | | Sex: * | ❑ Male ❑ Female | Email: | |

## B-12 Injection Questionnaire

Are you taking any medications? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No

Have you ever been treated for or had any known indications of or history of the following:

- Cobalt Allergy? ❑ Yes ❑ No
- Blood disorder? ❑ Yes ❑ No
- Disorder of the heart or blood vessels? ❑ Yes ❑ No
- Nervous or mental disorder ❑ Yes ❑ No
- Recent chest pain or heart attack? ❑ Yes ❑ No
- Convulsions? ❑ Yes ❑ No
- Epilepsy? ❑ Yes ❑ No

I hereby certify that the foregoing history is true and complete to the best of my knowledge and have had an opportunity to ask questions that were answered to my satisfaction, and do wish to receive this procedure fully understanding the risks and the benefits. Risk and possible side affects could include soreness, fever, aching for one or two days. As with most drugs or vaccines, there is possibility of allergic reaction or more serious reactions, even death, could occur. I hereby consent to the administration of the vaccine.

Furthermore, I hereby release and forever discharge for myself, my heirs, executors, administrators and assignees, PicMed of Oklahoma and their employees, owners and representatives, as well as the company sponsoring this event and their agents, representatives, employees, successors, assignees, governing bodies, and advisory committees from any and all claims, demands, actions and causes of action, which may result from participation in this program.

***Your personal information and results shall be held strictly confidential. I understand PicMed of Oklahoma will not bill insurance; however, forms/receipts are available for reimbursement.***

I may revoke this authorization at any time by providing my written revocation to PIC-MED OF OKLAHOMA or Walk in to sign a revoked. **Unless revoked, the consent will never expire.**

| | | | |
|---|---|---|---|
| Signature: | | Date: | |

**FOR CLINIC USE ONLY**

| Immunization Given | Mfg. | Lot# | Exp. Date | Injection Site | Administered By | Dose #1 | Dose #2 |
|---|---|---|---|---|---|---|---|
| | | | | R / L Deltoid IM<br>R / L Thigh Anterolateral | | | |
| | | | | R / L Deltoid IM<br>R / L Thigh Anterolateral | | | |
| | | | | R / L Deltoid IM<br>R / L Thigh Anterolateral | | | |

| | | | | | |
|---|---|---|---|---|---|
| I hereby authorize **Pic-Med** of Oklahoma to charge my credit card account. | | | Signature: | | |
| Card #: | | Expiration Date: | | CVC Code: (3 digits on back of card) | |

| Payment | |
|---|---|
| Cash | $_____ |
| Check | $_____<br>#_____ |
| Employer | $_____ |
| Medicare | $_____ |
| Credit Card | $_____ |