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

Pneumonia

Pneumonia Vaccine 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:	

Medicare ONLY Information

I agree that, if for any reason my Medicare claim is denied, I will still be held responsible for payment in full to PicMed for services rendered.	Medicare ID#:		DL#:	

Vaccine Questionnaire

Have you had a pneumonia shot within the last 5 years?	❑ Yes	❑ No
Are you 65 years or older?	❑ Yes	❑ No
If you are female, are you pregnant?	❑ Yes	❑ No
Do you have a fever today?	❑ Yes	❑ No
Do you have cold or flu symptoms today?	❑ Yes	❑ No
Do you have any health problems or allergic reactions that require you to see a physician?	❑ Yes	❑ No
Have you ever had a reaction to a Pneumonia shot?	❑ 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.

Signature:		Date:	

FOR CLINIC USE ONLY

Immunization Given	Mfg.	Lot#	Exp. Date	Injection Site	Administered By	Dose #1	Dose #2
				R / L Deltoid IM R / L Thigh Anterolateral			
				R / L Deltoid IM R / L Thigh Anterolateral			
				R / L Deltoid IM 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	$_____ #_____
Employer	$_____
Medicare	$_____
Credit Card	$_____