(PLEASE FILL OUT COMPLETELY)

Jewish Renaissance Foundation
"One People, One Heart"

JRF COMMUNITY HEALTH CENTER
REGISTRATION FORM

PATIENT INFORMATION

DATE: _____

LAST NAME: _____ FIRST NAME: _____ MI: ____ DOB: (MM/DD/YYYY): _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP CODE: _____

HOME #: _____ MOBILE # _____ EMAIL: _____

SOCIAL SECURITY #: _____-_____-_____ FAMILY SIZE: _____

PRIMARY LANGUAGE: [ ] English [ ] Spanish [ ] Other: _____ NEED INTERPRETER? [ ] Yes [ ] No

ETHNICITY: [ ] Hispanic (Latino) [ ] Non-Hispanic

MARITAL STATUS: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

ORIENTATION: [ ] Heterosexual (*NOT* gay or lesbian) [ ] Homosexual (gay or lesbian) [ ] Bisexual [ ] Not Sure [ ] Choose not to disclose [ ] Other

VETERAN: [ ] Yes [ ] No DISABLED: [ ] Yes [ ] No

INSURED INFORMATION

□ Self SUBSCRIBER: LAST NAME: _____ FIRST NAME: _____ MI: ____ DOB (M/D/Y): _____

INSURANCE: _____ POLICY #: _____ GROUP #: _____ EFFECTIVE DATE: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP CODE: _____

EMPLOYER: _____ TELEPHONE #: _____

INSURANCE TELEPHONE #: _____ RELATIONSHIP TO PATIENT: _____

EMERGENCY CONTACT

NAME: _____ TEL#: _____

DATA SURVEY

In an effort to comply with requirements regarding federal record-keeping and reporting, we ask that you complete the following data survey. Your cooperation is encouraged and appreciated.

RACE (MUST PICK AT LEAST ONE)	INCOME SOURCE (check off what applies)	LIVING ARRANGEMENTS
□ White (If Hispanic/Latino choose this option)	□ Employment: □ full-time □ part-time	□ Home Owner
□ Black (African-American)	□ SSI/ SSD	□ Rent
□ Asian	□ Migratory worker	□ Living with Family
□ American Indian/Alaska Native	□ TANF	□ Shelter
□ Native Hawaiian	□ Pension	□ Homeless
□ Other Pacific Islander	□ Self Employed	□ Other
□ Multiracial – *(select 2 or more above)*	□ Unemployed/Unemployment	□ Resident of public housing
	□ General Assistance/ Other	

SIGNATURE: I certify that the information provided is correct _____

JRFCHC USE ONLY - Patient Account #: _____ **Staff Initials:** _____ **Date:** _____

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Treatment Authorization

You are responsible for your own bill. As a courtesy, JRFCHC will submit charges to your insurance carrier. If you have no insurance, you will be required to set up payment arrangements with our financial counselor.

- I hereby assign, transfer, and set over to JRFCHC all of my rights, title, and interest to my medical reimbursement benefit under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I, revoking said authorization, give written notice. I understand that I am financially responsible for all charges whether they are covered by insurance.

- I authorize treatment for myself.

_____ _____

Patient Signature Date

Notice of Privacy Practices

I have read, and understand the Notice of Privacy Practices of JRFCHC. Upon request, a copy can be provided to the patient if necessary.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

JRF Community Health Center COVID Vaccine Consent Form

Section 1: Information to Receive Vaccine (please print)

PATIENT NAME (Last)	(First)	(M.I.)	**PATIENT'S DATE OF BIRTH** month_____ day_____ year _____	
IF MINOR- PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	**AGE**	**GENDER** M / F

COVID-19
Section 2: Screening for Vaccine Eligibility

The following questions will help us to know if you can get the COVID-19 vaccine. If you answer "YES" to one or more of the following four questions, you may be able to get the COVID-19 vaccine, but we will contact you to discuss your options.
Please mark YES or NO for each question.

	YES	**NO**	**Don't Know**
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID vaccine? List which one_____			
3. Do you have a severe allergies, or a history of severe allergic reactions? Including those needing the use of Epipen or that caused you to go to the hospital: If so, please list here: _____			
4. Have you ever had an allergic reaction to the following: a. A component of the COVID vaccine including polyethylene glycol (PEG) which is found in some medications, such as laxatives and preparations for colonoscopy procedures? b. Polysorbate? c. A previous dose of COVID-19 Vaccine? d. Was the allergic reaction after receiving another vaccine or other injectable medication? (This would include severe allergic reaction (e.g. anaphylaxis) that require treatment with Epinephrine (EpiPen) or that caused you to go to the hospital. It would include a reaction that occurred within 4 hours that caused hives, swelling, respiratory distress, including wheezing.) e. A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction			
5. Have you ever had a severe allergic reaction (e.g. anaphylaxis) to something other than a component of COVID-19, polysorbate, or any vaccine injectable medication? This would include food, pet, environmental, or oral medication allergies.			
6. Have you had any other vaccines in the last 14 days? _____			
7. Have you had a fever of over 100.0 within the last 72 hours?			
8. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? (Note: this answer will not affect the ability to receive the vaccine)			
9. Are you pregnant or nursing, or planning on getting pregnant?			
10. Are you considered immunocompromised?			
11. Do you have a bleeding disorder or taking any blood thinners?			
12. Have you received any passive antibody therapy as treatment for COVID 19?			
13. Do you have dermal fillers?			

Section 3: Consent

CONSENT FOR VACCINATION:

I have read or had explained to me the Vaccine Information Statement for the vaccine above and understand the risks and benefits. I have also been given instructions on V-safe and how to register for the program.

I GIVE CONSENT to the JRF Community Health Center and its staff to administer this vaccine. (If this consent form is not signed, then you will not be vaccinated)

I DO NOT GIVE CONSENT to the JRF Community Health Center and its staff to administer this vaccine.

Signature of Patient/Parent/ Legal Guardian _____ Relationship to Patient _____

Date: month_____day_____year_____

FOR OFFICE USE ONLY

FOR VACCINES ADMINISTERED IN PARTNER WITH EDISON DEPARTMENT OF HEALTH AT THE FOLLOWING LOCATION:

EDISON TOWNSHIP SENIOR CENTER 2963 WOODBRIDGE AVENUE, EDISON, NJ 08837

☐ Dose 1 of 2 Administered	☐ Dose 2 of 2 Administered
Vaccine Manufacturer: Moderna	Lot #
Expiration Date:	Intramuscular Injection Given: ☐ Left Deltoid ☐ Right Deltoid
Administered By: Print Title and Name:	Signature:
Date Given:	☐Moderna EUA Given to Patient ☐V-Safe Given to Patient
Observation ☐ 15 minutes	Observation ☐ 30 minutes