ERIKA GONZALEZ, M.D.
BOARD CERTIFIED ALLERGY & IMMUNOLOGY

JOHN P. DICE, M.D.
BOARD CERTIFIED ALLERGY & IMMUNOLOGY

JOEL A. REYES, D.O.
MANAGING PARTNER

PATIENT INFORMATION SHEET

DATE:____________________

PATIENT'S NAME ____ DOB ________________________ M / F

RACE____ETHNICITY______________________________

ADDRESS____ PHONE (____) ____________________________

CITY___________________________________ STATE ________ ZIP_____________COUNTY______________

EMAIL____

BEST NUMBER TO REACH YOU DURING THE DAY (_____) ___________________________

EMERGENCY CONTACT PHONE#____

RELATIONSHIP TO PATIENT ____

INSURANCE INFORMATION: *Please attach a copy of the front and back of your insurance card and Identification Card*

❏ NO INSURANCE (If you do not have insurance please provide SSN#) SSN#:_____- _____-_____ ‘

INSURANCE ____

POLICY HOLDER___________________________ POLICY HOLDER'S DOB _______________________________

GROUP ID ________________________ MEMBER NUMBER ____

MINORS

Please choose one of the below options:_________________________

☐ YES, I AGREE: I GIVE MY CONSENT FOR MY CHILD TO BE VACCINATED WITH THEIR FIRST AND SECOND DOSE OF THE PFZIER COVID-19 VACCINE BY SOUTH TEXAS ALLERGY AND ASTHMA MEDICAL PROFESSIONALS. I UNDERSTAND THIS ALLOWS MY CHILD TO BE VACCINATED.

☐ NO, I DO NOT AGREE: I DO NOT CONSENT FOR MY CHILD TO BE VACCINATED WITH THEIR FIRST AND SECOND DOSE OF THE PFIZER COVID-19 VACCINE BY SOUTH TEXAS ALLERGY AND ASTHMA MEDICAL PROFESSIONALS.

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF MEDICAL INFORMATION

I ____, HEREBY AUTHORIZE THE RELEASE OF MY INFORMATION RELATING TO ALL CLAIMS FOR BENEFITS SUBMITTED ON BEHALF OF MYSELF AND/OR DEPENDENTS. I FURTHER EXPRESSLY AGREE AND ACKNOWLEDGE THAT MY SIGNATURE ON THIS DOCUMENT AUTHORIZES MY PHYSICIAN TO SUBMIT CLAIMS FOR BENEFITS FOR SERVICES RENDERED WITHOUT OBTAINING MY SIGNATURE ON EACH AND EVERY CLAIM TO BE SUBMITTED FOR MYSELF AND/OR DEPENDENTS, AND THAT I WILL BE BOUND BY THIS SIGNATURE AS THOUGH THE UNDERSIGNED HAD PERSONALLY SIGNED THE PARTICULAR CLAIM. I ____________________________, HEREBY AUTHORIZE MY INSURANCE COMPANY(IES) TO PAY AND HEREBY ASSIGN DIRECTLY TO SOUTH TEXAS ALLERGY AND ASTHMA MEDICAL PROFESSIONALS ALL BENEFITS PAYABLE FOR SERVICES PERFORMED.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED. AS A COURTESY SOUTH TEXAS ALLERGY AND ASTHMA MEDICAL PROFESSIONALS WILL FILE MY INSURANCE CLAIM FOR ME. COPAY AND DEDUCTIBLES ARE DUE AT TIME OF VISIT. IF MY INSURANCE COMPANY DOES NOT PAY WITHIN 90 DAYS, I WILL BE BILLED FOR SERVICES RENDERED. IF AN INSURANCE CHECK IS LATER RECEIVED FROM MY INSURER, ANY OVERPAYMENT WILL BE REFUNDED TO ME.

Signature / Guardian ____________________

PLEASE BRING DOCUMENTS WITH YOU TO YOUR APPOINTMENT

South Texas Allergy
& Asthma Medical
Professionals
O: (210) 616- 5385
F: (210) 647- 1012
www.staampallergy.com

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COVID-19 VACCINATION ACKNOWLEDGMENT

By signing this form, I acknowledge the following:

- **I voluntarily elected to receive the Pfizer COVID-19 vaccination at STAAMP after carefully considering the risks and benefits;**
- **STAAMP advised me to consult with my medical provider to discuss my personal risks, benefits, and potential side effects of receiving the COVID-19 vaccination;**
- **I received information about the possible side effects of the COVID-19 vaccine, as presented in the Emergency Use Authorization Fact Sheet found at https://www.fda.gov/media/144414/download**
- **I received information about the known risks and side effects, the possibility of unknown adverse reactions, and the need for continued masking/social distancing after receiving the COVID-19 vaccination found at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/expect/after.html?s_cid=10509:side%20effects%20of%20covid%20vaccine:sem.ga:p:RG:GM:gen:PTN:FY21**
- **I understand that if I experience adverse side effects after receiving the COVID-19 vaccination, I will contact my primary care physician or STAAMP at (210) 616- 5385 immediately.**
- **I understand that the COVID-19 vaccinations given at STAAMP will be tracked and reported to ImmTrac, and as otherwise required by the local, state and federal government.**
- **I was given information and encouraged to sign up for V-SAFE (smartphone based tool designed to tell CDC about any side effects you may experience after getting COVID-19 Vaccine).**

Printed name: ____________________________

Signature: ____________________________ **Date:** ______________________

PLEASE BRING DOCUMENTS WITH YOU TO YOUR APPOINTMENT