INGHAM COUNTY HEALTH DEPARTMENT - INFLUENZA CLINIC **Clinic Site: _____**

Registration Form – Patient Information **Encounter #:_____**

PLEASE PRINT CLEARLY-front & back

COUNTY EMPLOYEES ONLY:

WHAT DEPARTMENT:_____

Last / Family Name:_____

Maiden Name: _____

First Name: _____

Address: _____

City, State, Zip: _____

County of Residence: _____

Date of Birth: _____Age: _____

Marital Status: ⌗ Married ⌗ Separated ⌗ Divorced ⌗ Widowed ⌗ Not Married

Daytime Phone Number: _____

Cell/Alternate Phone Number: _____

Please answer the following questions:

Patient is: _____male _____female

Patient is: ⌗Hispanic ⌗ Non-Hispanic ⌗ Unknown

Patient Speaks: ⌗ English ⌗ Arabic ⌗ Spanish ⌗ Other (specify): _____

Patient is (select all that apply):

⌗ American Indian ⌗ Asain ⌗ Black/African American ⌗ Native Hawaiian ⌗ Pacific Islander ⌗ White ⌗ Unknown/Refused

Patient Homeless Status:

⌗ Not Homeless ⌗ Homeless Shelter ⌗ Transitional ⌗ Doubling Up ⌗ Other ⌗ Street ⌗ Unknown Status

Veteran Status: (an individual who completed service in the Uniformed Services of the United States):
⌗ Yes ⌗ No

The following information is required to determine eligibility in the Sliding Fee Discount Program. Eligibile patients may qualify for a discount in vaccine administration fees.

Total Family Income: $_____ ⌗ Weekly ⌗ Monthly ⌗ Yearly (check only one)

How many people live in the house: _____

PLEASE READ AND SIGN THE STATEMENT BELOW:

Receipt of Privacy Notice

I acknowledge that I have been offered a copy of the Ingham County Health Department Notice of Health Information and Privacy Practices…… ⌗ Accept ⌗ Decline

Authorization for Vaccine Administration and Billing:

I have read, or have had explained to me, the information in the Vaccine Information Statement. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risk of specifed vaccine(s). I ask that the vaccine(s) be given to me, or to the person named above for whom I am authorized to make this request.

I authorize the release of any information necessary to process insurance claims for immunization services. I request that any money due me for the medical benefits be assigned to the Ingham County Health Department (ICHD). I am responsible for any deductibles, copays and non-covered benefits. If I have insurance that does not have a contract with the ICHD, I understand that I am responsible for payment of services today.

PRINT HERE: Patient or Parent/Guardian Name (if patient is under 18 years old): _____

SIGN HERE: Patient or Parent/Guardian (if patient is under 18 years old):_____

DATE:_____

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Patient Name: _____

(Last / Family) (First) (Middle Initial)

Date of Birth: _____/_____/_____ Age: _____ (months if under 3 years old)

PLEASE CHECK THE APPROPRIATE BOX FOR EACH QUESTION:

1. Have you had a fever within the past 2 days?.....☐Yes or ☐No
2. Have you had a flu shot before?.....☐Yes or ☐No
3. Have you ever had a serious reaction to a flu shot or any previous immunization?.....☐Yes or ☐No
4. Do you have any allergies? If so, list:_____☐Yes or ☐No
5. Do you have a history of Guillain Barre Syndrome?.....☐Yes or ☐No
6. Have you had a pneumonia shot in the past? If yes, year:_____☐Yes or ☐No

IMPORTANT NOTICE: The Ingham County Health Department does not participate with all commercial insurance plans and Medicare health plans. We can attempt to bill any health insurance plan as requested, however, non-covered charges are the responsibility of the patient.

Does your insurance cover immunizations? ☐ Yes or ☐ No

Primary Insurance – A copy of your insurance card(s) is required

Name of Insurance: _____ Policyholder's Name:_____

Subscriber ID / Contract Number: _____ Policyholder's Relationships to Patient:_____

Group #:_____ Policyholder's Date of Birth:_____

Secondary Insurance

Name of Insurance: _____ Policyholder's Name:_____

Subscriber ID / Contract Number: _____ Policyholder's Relationships to Patient:_____

Group #:_____ Policyholder's Date of Birth:_____

***********THE FOLLOWING IS FOR STAFF USE ONLY***********

Admin Codes: ☐ **90471 – 1st Injection** ☐ **90472 – Addt'l Injection(s) x____** ☐ **G0008 MC Flu** ☐ **G0009 MC Pneumonia**

Effective 10/1/15 use Diag code Z23

Key Codes: [1]**Given: V** = VFC, **P** = Private [2]**Site Key:** LA = Left Arm, RA = Right Arm, LL = Left Leg, RL = Right Leg, N = Nasal

Vaccine/ VIS Given	Given[1]		Vaccine	Vaccine Lot #	Site[2]	Vaccine Administrator	VIS Date
	□ V □ P	90685	**Influenza IIV4 (6 mo – 35 mo), 0.25 mL QUAD** Fluzone (Sanofi), SYR				8/7/15
	□ V □ P	90686	**Influenza IIV4 (3 yrs & older), 0.5 mL QUAD** Fluarix (GSK), SYR Fluzone (Sanofi), SYR				8/7/15
	□ V □ P	90662	**Influenza IIV3 (65 yrs & older), 0.5 mL** Fluzone **High Dose** (Sanofi), SYR				8/7/15
	□ V □ P	90673	**Influenza RIV3 (18 – 49 yrs), 0.2 mL** Flublok (Protein Science), SDV				8/7/15
	□ V □ P	90732 90670	**Pneumococcal Polysaccharide (PPSV23-Merck), SDV** **Pneumococcal Conjegate (PCV13-WAL), SYR**				4/24/15 11/5/15