Patient Information Sheet

C F I

☐ VFC
☐ Payment

Patient Information (Please Print Legibly)

Patient Legal Name: ____

Preferred Name:____________________________ Maiden/Previous:_________________________

Patient Birthdate: __________________________ Patient Age _____________________________

Patient Gender at Birth: ☐ Male ☐ Female

Patient Address:____

City: _________________________________ State: ___________ Zip Code:__________

Patient Phone Number: (_______) ________-_______________

Email: ____

Patient Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other__________________

If **Patient** is under 18 provide the following:

Patient's Parent/Legal Guardian Name: ____

Patient's Parent/Legal Guardian Date of Birth: __________________________________

Relationship to **Patient**: ____

Insurance Information: (Please Print)

Please have card ready

Insurance Company: ____

Policy or Subscriber Id#: ______________________________

Policy Holder Name: ____

Policy Holder Birthdate: ______________________________

Policy Holder Relation to Patient: _______________________

Policy Holder Address (If different from above): ____

City: ___________________________ State: _______________ Zip Code: _______________

Policy Holder Phone Number (If different from above): (_______) ________-_______________

**** PLEASE TURN OVER TO COMPLETE ****

Insurance Information

My current insurance status is:

☐ Uninsured. Patient does not have health insurance.

☐ Insured. Patient does have health insurance.

X____

Signature of Client (or Parent/Guardian/Representative) Date

HIPAA

I acknowledge that I can request a copy of the Bear River Health Department (Health Department) Notice of Privacy Practices-For Protected Health Information (Notice) which I have or will carefully review, and acknowledge my rights for a more complete description and understanding of potential uses, disclosures of and/or requests for such Protected Health Information by the Health Department.

I acknowledge that the Health Department reserves the right to change the terms of its Notice at any time. I acknowledge the right to obtain a copy of the current revised Notice at any Health Department office.

X____

Signature of Client (or Parent/Guardian/Representative) Date

Consent for Services

I acknowledge that I will be provided with information about the vaccine I am receiving today. I will have a chance to ask questions that will be answered to my satisfaction. I believe I understand the benefits and risks of the vaccine.

X____

Signature of Client (or Parent/Guardian/Representative) Date

Are you allergic to eggs: ☐ Yes ☐ No

For Office Use Only:

Payment Method: (Circle One) Cash Check Charge Amount Collected: $________________________

Employer Billing: ____

Flu Lot: ____ Site: ____________________

COVID Lot: ______________________________________ Site: ____________________

Other Lot: ______________________________________ Site: ____________________

Nurse Initials: ___________________