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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Information** | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | **MRN:** | | |  | | | | | |  |
| **Last Name:** | | |  | | | | | **First Name:** | | |  | | | | **Middle Name:** | | | | | |  | | | |  |
| **Date of Birth:** | | | |  | | | **Age:** |  | Years | |  | | Months (if under age 5) | | | | | | | **Gender:** | | | Male | Female |  |
| **Address:** |  | | | | | | | | | | | | | | | | | | | | | | | |  |
| **Mailing Address:** | | | | |  | | | | | | | | | | | | | | | | | | | |  |
| **Telephone:** | | |  | | | | | | | **Cell Phone:** | | | |  | | | | | | | | | | |  |
| **Race:** | | American Indian/Alaskan Native  Native Hawai’ian/Pacific Islander | | | | | | | | | | Asian  Decline to Answer | | | | | | White  African American | | | | | | |  |
| **Ethnicity:** | | Hispanic | | | | Not Hispanic | | | | | | Decline to Answer | | | | | **Primary Language:** | | | | |  | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | |  |

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| **Patient Screening Questions** | | |
|  | **Check One:** | |
| Does the patient have a fever or feel sick today? | Yes | No |
| Does the patient have allergies to medicines, food, latex or vaccines? | Yes | No |
| Has the patient had a bad reaction to a vaccination? | Yes | No |
| Has the patient had a seizure or a brain problem? | Yes | No |
| Does the patient have cancer, leukemia, AIDS or other immune system problems? | Yes | No |
| Does the patient have heart disease, lung disease, kidney disease, diabetes, asthma, anemia or other long-term complication? | Yes | No |
| Is the patient taking aspirin as long-term therapy? | Yes | No |
| Does the patient have a cochlear implant? | Yes | No |
| Has the patient been diagnosed with a spinal fluid leak? | Yes | No |
| Has the patient taken cortisone, prednisone, other steroids or cancer treatments in the last 3 months? | Yes | No |
| Has the patient received blood, blood products or immune globulin (IG) in the past year? | Yes | No |
| Is the patient pregnant or planning to become pregnant? | Yes | No |
| Has the patient received vaccines in the past month? | Yes | No |
| Has the patient ever fainted after injections? | Yes | No |
| Has the patient had chicken pox? If yes, estimated date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes | No |

**Please complete the following sections:**

|  |  |  |
| --- | --- | --- |
| **Immunization Coverage Information** | **Staff Use Only** | |
| Please check one *(staff to attach copy of insurance card if available)*: | **0-18 Years** | **19+ Years** |
| Patient has **NO** health insurance | VFC – N | B/O317 |
| Patient has Oregon Health Plan | VFC – M | B |
| Patient qualifies as American Indian or Alaskan Native (ages 0–18 years) | VFC – A | N/A |
| Patient’s insurance **does not ever** cover immunizations | VFC – F | B/O317 |
| Patient’s insurance covers immunizations | B | B |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Insurance Information** *(if applicable)* | | | | | | | | | |
| DCHS only accepts the following insurance coverage plans  Please indicate  if you have one of these plans: | | | | | | | | | |
| Cigna | | | Moda | | | Providence | | | |
| First Choice Health Plans | | | Oregon Health Plan | | | Regence Blue Cross Blue Shield | | | |
| Lifewise | | | PacificSource | | | United Healthcare / Tricare | | | |
|  | | | | | | | | | |
| **Policy Holder’s Information:** | | | | | | | | | |
| **Last Name:** |  | | | **First Name:** |  | | **Date of Birth:** |  |  |
|  | | | | | | | | (MM/DD/YYYY) |  |
| **Relationship to patient:** | |  | | | |  | | | |
| ***A copy of your insurance card is necessary in order to bill your insurance company.*** | | | | | | | | | |
|  | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- |
| I have received the Vaccine Information Statement(s) for the vaccine(s) to be given, and all of my questions have been answered. I request that the vaccine be given to me or to the person named above, for whom I am responsible. I allow the release of any information needed to process insurance claims and request payments of medical benefits, and I have received this clinic’s HIPAA Notice of Privacy Practices. | | | | | | |
|  |  |  |  |  |  |  |
|  | Printed Name |  | Relationship to Patient (Parent, etc.) |  | Parent’s Date of Birth |  |
|  |  |  |  |  |  |  |
|  | Signature |  |  |  | Date |  |
|  | | | | | | |