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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 plansPlease indicate [x]  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 |  |
|  |