INGHAM COUNTY HEALTH DEPARTMENT

INFLUENZA REGISTRATION FORM
PLEASE PRINT CLEARLY

CLINIC SITE: _____

ENCOUNTER #: _____

COUNTY EMPLOYEES ONLY:

WHAT DEPARTMENT:_____

LAST/FAMILY NAME: _____ **MAIDEN NAME:** _____

FIRST NAME: _____ **DATE OF BIRTH:** _____ **AGE:** _____

ADDRESS: _____ **CITY, STATE, ZIP:** _____

____ MALE ____ FEMALE **COUNTY OF RESIDENCE:** _____ **VETERAN:** ___ YES ___ NO

DAYTIME PHONE NUMBER: _____ **CELL/ALTERNATE PHONE NUMBER:** _____

MARITAL STATUS OF PATIENT:
___ MARRIED
___ SEPARATED
___ DIVORCED
___ WIDOWED
___ NOT MARRIED

PATIENT IS:
___ HISPANIC
___ NON-HISPANIC
___ UNKNOWN

PATIENT SPEAKS:
___ ENGLISH
___ ARABIC
___ SPANISH
___ OTHER (specify): _____

PATIENT IS (select all that apply): ___ AMERICAN INDIAN ___ ASIAN ___ BLACK/AFRICAN AMERICAN ___ NATIVE HAWAIIAN ___ PACIFIC ISLANDER ___ WHITE ___ UNKNOWN/REFUSED

PATIENT HOMELESS STATUS: ___ NOT HOMELESS ___ HOMELESS SHELTER ___ TRANSITIONAL ___ DOUBLING UP ___ STREET ___ OTHER ___ UNKNOWN STATUS

FINANCIAL SCREENING FOR UNINSURED (must be completed if you would like to qualify for a discount of the administration fee):
The following information is required to determine eligibility in the Sliding Fee Discount Program. Eligible patients may qualify for a discount in vaccine administration fees.
Total Family Income: $_____ Weekly Monthly Yearly (circle 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 (VIS). I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the specified vaccine. I ask that the vaccine 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 today's services.

PRINT PATIENT NAME HERE (or parent/guardian name if patient is under 18 years old): _____

SIGN PATIENT NAME HERE (or parent/guardian name if patient is under 18 years old): _____

TODAYS DATE: _____

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PATIENT NAME: _____
(LAST/FAMILY NAME) (FIRST) (MIDDLE INITIAL)

DATE OF BIRTH: _____ AGE: _____ (in months if under 3 years old)

PLEASE ANSWER BELOW QUESTIONS:

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? ___ Yes (If yes, list): _____ 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? ___ Yes (If yes, what year?)_____ 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 or ___ Don't know

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

Name of Insurance: _____ Policyholder's Name: _____

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

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

Secondary Insurance (if applicable)

Name of Insurance: _____ Policyholder's Name: _____

Subscriber ID / Contract Number: _____ Policyholder's Relationship 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___ - For Medicare Admins ___G0008 MC Flu ___G0009 MC Pneumonia

DATE & VIS GIVEN	GAVE VFC OR PRIVATE	PROCEDURE CODE	VACCINE TYPE	VACCINE LOT NUMBER	SITE GIVEN	VACCINE ADMINISTRATOR	VIS DATE
	___V OR ___P	90653	INFLUENZA FLUAD (65 YRS & OLDER) - SEQIRUS				8/15/19
	___V OR ___P	90662	INFLUENZA IIV4 FLUZONE (65 YRS & OLDER) - SANOFI				8/15/19
	___V OR ___P	90672	INFLUENZA LAIV4 FLUMIST (2 YRS – 49 YRS) – NASAL				8/15/19
	___V OR ___P	90674	INFLUENZA FLUCELVAX (4 YRS & OLDER) - SEQIRUS				8/15/19
	___V OR ___P	90682	INFLUENZA RIV4 FLUBLOK (18 YRS & OLDER)				8/15/19
	___V OR ___P	90686	INFLUENZA IIV4 (6 MTHS & OLDER) – GSK = FLUARIX - SANOFI = FLUZONE – ID BIOMEDICAL = FLULAVAL				8/15/19
	___V OR ___P	90732	PPSV23 – MERCK (2 YRS & OLDER)				10/30/19
	___V OR ___P	90670	PCV13 – WYETH (6 WKS & OLDER)				10/30/19