Van Wert County General Health District-Child

1179 Westwood Dr., Ste. 300 Van Wert, OH 45891 (419)238-0808

Legal Name: Last _____ First _____ Middle _____
Street Address & PO Box _____ Apartment # _____
City _____ State _____ Zip _____ Sex M F
Social Security # _____/_____/_____ Birth date _____ /_____ /_____ Age _____
Home Phone # _____Cell Phone # _____
Primary Care Physician: _____ Is child on **WIC**? YES NO
Mother/Guardian Name: _____ Phone #_____
Address (if different from patient)_____
Email Address_____
Father/Guardian Name: _____ Phone #_____
Address (if different from above)_____
Email Address_____
Emergency Contact:_____Relationship_____Phone #_____
Person Responsible for Payment: _____
Primary Insurance: _____ Name on card_____
Birthdate _____ Social Security # _____
ID #_____ Employer Name _____
Secondary Insurance: _____ Name on Card _____
Birthdate _____ Social Security # _____
ID #_____ Employer Name _____

Consent for assignment of benefits: I give consent for my insurance to be billed for services received today at the Van Wert County Health Department. I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be stated to be my responsibility by the insurance agency, as required by any contract with my insurance agency and state regulation. I also understand that my contract with my insurance agency may or may not cover some services. It is my responsibility to get information from my health insurance agency about services that are covered. If I get care outside of my health insurance plan, I am aware that I may be responsible for all charges that may be due. A returned check fee of $25.00 will be charged to you for a check returned for insufficient funds, stopped payment or closed account.

Signature _____ **Date** _____
Signature _____ **Date** _____
Signature _____ **Date** _____
Signature _____ **Date** _____
Signature _____ **Date** _____
Signature _____ **Date** _____

OR: My insurance is not in-network or it is a non-covered service(s). I will ***self-pay*** for all services & fees.

Signature _____ **Date** _____
Signature _____ **Date** _____
Signature _____ **Date** _____
Signature _____ **Date** _____
Signature _____ **Date** _____

OR: I do not have insurance coverage for my child_____

Signature _____ **Date** _____
Signature _____ **Date** _____
Signature _____ **Date** _____
Signature _____ **Date** _____
Signature _____ **Date** _____

********** Please complete the back of this form**********

Patient name: Date of birth:

This consent is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to let you know your rights to privacy with respect to your health care information.

- I give my consent to the Van Wert County Health Department (VWCHD) to use and disclose my protected health information for the purposes of treatment, payment and operations of my care and this clinic.
- I understand that my child's immunization record will be entered into the Ohio Immunization Registry (IMPACT SIIS) unless I sign a form for removal. I also understand that other entities such as but not limited to: Parent or Guardian, WIC, Physician, Other Health Departments, Dept. of Job and Family Services, School or Preschool, Head Start or Daycare, Hospital, and Ohio Department of Health might be contacted for information or records may be released when deemed necessary.

Consent for release of information for payment and operations: I authorize VWCHD to give information to the identified insurance carriers(s) for any and all payment activities.
A copy of the Privacy statement is hanging up in the waiting room and a copy can be given if asked for by the client.
Consent related to privacy Notice: I have had a chance to review the Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may get these changed notices by contacting VWCHD by phone or in writing. I understand I have the right to ask how my protected health information will be used and/or given out.
Signature for HIPAA Consent: _____ **Date**: _____

Screening Checklist for Contraindications to Vaccines for Children and Teens:
For **Parents/Guardians**: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, ask your healthcare provider to explain it. Circle those that apply.

1.) Is your child sick today?	Yes	No	Don't know
2.) Does the child have allergies to medications, food, a vaccine component, or latex?	Yes	No	Don't know
List if applicable: _____			
3.) Has the child had a serious reaction to a vaccine in the past?	Yes	No	Don't know
4.) Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy? Has the child ever had Guillain-Barre syndrome?	Yes	No	Don't know
List if applicable: _____			
5.) If the child to be vaccinated is between ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	Yes	No	Don't know
6.) If your child is a baby, have you ever been told he or she has had intussusception?	Yes	No	Don't know
7.) Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	Yes	No	Don't know
8.) Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	Yes	No	Don't know
9.) In the past 3 months, has the child taken medications that weaken their immune system, Such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	Yes	No	Don't know
10.) In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	Yes	No	Don't know
11.) Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	Yes	No	Don't know
12.) Has the child received vaccinations in the past 4 weeks?	Yes	No	Don't know

Form completed by: **Date:** **Form Reviewed by:** **Date:**
Future Visits Reviewed and Initialed by **Parent/Guardian**:
Initial_____&date_____ Initial_____&date_____ Initial____&date_____ Initial____&date_____ Initial_____&date_____
Future Visits Reviewed and Initialed by **Nurse**:
Initial_____&date_____ Initial_____&date_____ Initial____&date_____ Initial____&date_____ Initial_____&date_____