MR # : _____

Van Wert County General Health District - ADULT (19 YRS. +)

1179 Westwood Drive, Suite 300, Van Wert, OH 45891 (419) 238-0808

PATIENT INFORMATION:			
Legal Name:	**Last**	**First**	**Middle**
Birth Date: / /	**Social Security#:**		**Race:**
Mailing Address:			**Apt./Lot #**
City:		**State:**	**Zip:**
Primary Phone #:		**Secondary Phone #:**	
Sex: M F	**Marriage Status:**	**Primary Care Physician:**	
Email:			
Emergency Contact:	**Relationship:**	**Phone #:**	

INSURANCE INFORMATION:	
Person Responsible for Payment:	
Primary Insurance:	**Primary Card Holder:**
Birth Date (Policy Holder):	**Employer Name:**
Insurance ID#:	**Group #:**
Secondary Insurance:	**Secondary Card Holder:**
Birth Date (Policy Holder)	**Employer Name:**
Insurance ID#:	**Group #:**

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 deductables, 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:**

Future Visits Reviewed and Initialed by **Patient/Guardian**:

Initial_____&date_____ Initial_____&date_____ Initial____&date_____ Initial____&date_____ Initial_____&date_____

MR # : _____

Patient Name: _____ Birth Date: _____

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.

***Impact SIIS Statewide Immunization Registry Impact SIIS (Statewide Immunization Information System)** is a central data processing point which provides an accurate, efficient way to ensure that Ohioans of all ages receive the right vaccinations at the right times without unnecessary repetition. This also ensures a permanent, secure location of your personal health information that can only be accessed by credentialed health professionals. I understand that this information will be submitted unless I complete a separate form for removal.

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 Vaccine for Adults:

For Patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider.

1.) Are you sick today?	YES	NO	N/A
2.) Do you have allergies to medications, food, a vaccine component, or latex?	YES	NO	N/A
List if applicable:			
3.) Have you ever had a serious reaction after receiving a vaccination?	YES	NO	N/A
4.) Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, blood disorder, no spleen, complement component deficiency, a cochlear implant, or spinal fluid leak? Are you on long-term aspirin therapy?	YES	NO	N/A
List if applicable:			
5.) Do you or does a close family member have cancer, leukemia, HIV/AIDS, or any other immune system problem?	YES	NO	N/A
6.) In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	YES	NO	N/A
7.) Have you had a seizure or a brain or other nervous system problem?	YES	NO	N/A
8.) During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	YES	NO	N/A
9.) Are you pregnant or is there a chance you could become pregnant during the next month?	YES	NO	N/A
10.) Have you received any vaccinations in the past 4 weeks?	YES	NO	N/A

Form completed by: **Date:** **Form Reviewed by:** **Date:**

Future Visits Reviewed and Initialed by **Patient**:

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_____