District Health Department #10 Clinic Patient Registration

(*Office Use Only*) CLIENT ID# / MCIR ID#

Birthdate: ___/_____/_____ **Age:** _____

County of Residence: ____________________

Legal Name: ______________________________________
First Middle Last

If patient is a minor, Parent/Guardian Name: ____________________

Address: ______________________________________

City: ____________________ **State:** ________ **Zip:** ____________

Home Phone: ____________ **Work:** ____________ **Cell:** ____________

E-mail: ____________________ **Text:** ____________

Sex/Gender: ___**Male** ___**Female** **Client's Marital Status:** ____________

Educational Level/Grade Level ____________________

Unemployed____ **Employed** _____ **Full-time** _____ **Part-time** _____ **Retired** _____

Occupation: ____________________

RACE
- ☐ Am. Indian/Alaskan Native
- ☐ Arabic
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Other ________

ETHNICITY
- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Latino

LANGUAGE
- ☐ English
- ☐ Spanish
- ☐ Other ____________
- ☐ Translation Needed

We provide Medicaid application assistance

Are you enrolled in Medicaid? Yes ___ No ___ **Medicare?** Yes ___ No ___ **Military?** Yes ___ No ___

Do you have other insurance? Yes __ No __ **Insurance Co. Name:** ____________________

Please copy current insurance card(s): *If applicable*, does it cover immunizations? **Yes __ No __**

Enrollment or Contract #____________________**Group #**____________________

Do you smoke? Yes ___ No ___ Never a smoker? ____________ Former Smoker? ____________

If yes, please answer the next two items: Current daily smoker? Yes ___ No ___ Current some-days smoker? Yes ___ No ___

Are you willing to consider quitting? Yes___ No____

Current Medications (Describe):	Date Started	Dose	Current Medications	Date Started	Dose

Does the patient have allergies to medications, food, latex or any vaccine? If so, what:

Allergic to (Describe):

____

____

Has the patient had a serious reaction to a vaccine in the past or received vaccines in the past 4 weeks? **Yes ___ No ___**

Is the patient sick today? **Yes ___ No ___** Explain: ____________________

Has the patient had a seizure, brain problem or Guillain-Barre? **Yes ___ No ___** Explain: ____________________

Does the patient have cancer, leukemia, AIDS, other immune system problem or long term chronic health problems including asthma or wheezing in 2-4 yrs old? **Yes ___ No ___** Explain: ____________________

Has the patient taken cortisone, prednisone, other steroids, anticancer drugs, or radiation treatments in past 3 mos? **Yes ___ No ___**

Has the patient received a transfusion of blood or plasma or been given a medicine called immune (gamma) globulin in the past year. **Yes ___ No ___**

Is your child on long term aspirin therapy? **Yes ___ No ___**Explain: ____________________

Is the patient pregnant or is there a chance she could become pregnant in the next month? ____________ **Yes ___ No ___**

I give permission for my child to receive the following vaccinations by **checking the yellow highlighted boxes**.

I understand the benefits and risks of the specific vaccine and I request that the vaccine be given to my child in my absence.

I understand that the administration of the vaccine will be recorded in the MCIR (Michigan Care Improvement Registry).

Vaccine Type	Lot #	Site	Eligibility
☐ Menactra (Sanofi)	___________	___	______
☐ Tdap (Glaxo-Sanofi)	___________	___	______
☐ Varicella (Merck)	___________	___	______
☐ HPV (Merck)	___________	___	______
☐ Hep A (Glaxo-Sanofi)	___________	___	______
☐ Hep B (Glaxo-Sanofi)	___________	___	______
☐ MMR	___________	___	______
☐ Polio	___________	___	______
☐ Flu 0.5 ml	___________	___	______
☐ Flu-Mist	___________	___	______
☐ TB Skin	___________	___	______

What are the fees for this service? Most insurances, including Medicaid cover the cost of the vaccine and administration fees. If you do not have insurance for your child, we are able to provide the vaccine at no charge. Administration fees are separate from the cost of the vaccine. The administration fee is based on a sliding fee scale ($5.40 -$27) vaccine, when income and family size is provided. If you do not have insurance for your child, administration fee payment is expected at time of service (we accept cash, checks, or money orders).

Parent/Legal Guardian Signature ______________________________ Date __________

Phone Consent Witness ____________________ Date __________

Date given: __________ Administered by: ______________________________

DISTRICT HEALTH DEPARTMENT #10 CLINIC SIGNATURE FORM

I give my permission to District Health Department #10 to release my medical information to my medical insurance provider as required for billing purposes.

If your service(s) are not a covered benefit under your insurance plan and you have not met your deductible and/or co-pays or are out-of-network, you will be billed for the cost of the service and/or administration fees as directed by the State of Michigan.

I acknowledge receiving a current Notice of Privacy Practices on ___/___/____ from District Health Department #10.
(Date)

I understand that the Notice contains my rights and the Health Department's responsibilities with regard to my protected health information.

IMMUNIZATION CLIENTS:
I have been given a copy and have read, or have had explained to me, the information contained on the appropriate Vaccine Information Statement (VIS) about the disease(s) and the vaccine(s) which are to be administered today.
If your service(s) are not a covered benefit and you are eligible for the VFC Program (Vaccines for Children), you will be billed the administration fee only.

I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the specific service(s) and I ask that the service(s) I have requested be given to me, or to the person named above for whom I am authorized to make this request and I ask that the administration of the service(s) be recorded.

Signature: ______________________________

3/30/16