PLEASE COMPLETE **ALL** INFORMATION ON THIS SIDE ONLY (please print)

Legal Name: _____ Birth Date: _____ Age: _____

Race: _____ ☐ American Indian/Alaskan Native ☐ Hispanic Male/Female

Home address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cell Phone: _____ SS#: _____ Medicaid: Y / N

Insurance Company: _____ Policy Number: _____

Insurance Address: _____

****** Please provide copy of insurance card to clerk ******

For Minor Children:

Child's Mother: _____ Child's Father: _____

Legal Guardian's Name (if applicable you must present legal documents): _____

Who brought child today? Mother Father Other _____

Do you need proof of shots (Form 680) for: School Daycare Children & Families Social Security

Grade: _____ Has this person ever received shots here? ☐ Yes ☐ No

If no, where were previous shots received? _____

PATIENT INFORMATION FOR IMMUNIZATIONS

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT THE PERSON TO RECEIVE SHOTS.

1. Is client sick or running a fever? ☐ Yes ☐ No
2. Has the client ever had an **allergic reaction** to any medication, food, or vaccine? If yes, please list allergy: _____ ☐ Yes ☐ No
3. Has client ever had a seizure or a brain problem? ☐ Yes ☐ No
4. Has client ever had a gamma globulin shot, transfusion of blood or plasma, or blood disorder? ☐ Yes ☐ No
5. Has client taken cortisone, prednisone or other steroids, anti-cancer drugs, or x-ray treatments in the **past three months?** ☐ Yes ☐ No
6. Does client have cancer, leukemia or other immune system problems? ☐ Yes ☐ No
7. Is the client pregnant or at risk of becoming pregnant in the next three months? ☐ Yes ☐ No
8. If client is a child, have they had chicken pox? If yes, when? _____ ☐ Yes ☐ No
9. Has client had **any vaccinations** in the **past 4 weeks?** ☐ Yes ☐ No
10. Is client requesting immunizations due to an injury, accident, or exposure? ☐ Yes ☐ No
    If yes, please explain: _____
11. Has client traveled to West Africa in the last 21 days? ☐ Yes ☐ No
12. Has client been in contact with any person who has been to West Africa in the last 21 days? ☐ Yes ☐ No

I hereby authorize the release of medical information to insurance carriers concerning all payments for medical services rendered to me. I understand I am responsible for any amount not covered by insurance.

Signature: _____ Date: _____