_____PRIVATE

HAMPSHIRE COUNTY HEALTH DEPARTMENT

2017-2018 Influenza Registration/Consent Form _____VFC

Patient Information			
Last Name:	**First Name:**		**Middle Initial:**
Maiden Name (if applicable):	**Mother's Maiden Name:**		
Mailing Address:			
City:	**State:**	**Zip Code:**	
Home Phone:	**Cell Phone:**	**Work Phone:**	
Primary Care Physician or Pediatrician:			
Date of Birth:	**Sex: Male ◯ Female ◯**	**Marital Status: S ☐ M ☐ D ☐ W ☐**	
Social Security Number (over 18 years of age):			

Responsible Party – If patient is a minor please list the parent or legal guardian		
Last Name:	**First Name:**	**Middle Initial:**
Relationship to Patient:		
Address (if different from above):		
City:	**State:**	**Zip Code:**
Date of Birth:	**Phone Number:**	
Social Security Number:		

In Case of Emergency
Emergency Contact Name:
Emergency Contact Number:
Relationship to Patient:

Primary Medical Insurance		
Insurance Company Name:		
Insurance Company Address:		
City:	**State:**	**Zip Code:**
Insurance Company Phone Number:		
Policy Holder Name:		
Policy Holder Date of Birth:	**Relationship:**	
Policy Identification Number:		
Group Number:		

The HCHD Notice of Privacy Practices provides information about how we may use and disclose your protected information. The Notice of Privacy Practices is subject to change. A copy of our notice is available upon request. By signing this form, you acknowledge that they HCHD Notice of Privacy Practices was made available to you.

You must be 18 years of age to sign this form. I have read or had explained to me the Vaccine Information Statement for the vaccine I am to receive and I understand the risk and benefits.

Hampshire County Health Department can bill the insurance listed for the immunizations. I request that payment of authorized third party benefits be made to Hampshire County Health Department for services furnished by the department. ***Submission of insurance information does not guarantee coverage. I understand that if the insurance company does not cover the vaccine(s), I will be responsible for payment.***

Patient Signature:_____ **Date:**_____

Parent/Guardian Signature:_____ **Date:**_____

Turn Over ➡

HAMPSHIRE COUNTY HEALTH DEPARTMENT
2017-2018 Influenza Registration/Consent Form

_____PRIVATE
_____VFC

Please answer the following questions:

	Yes	No
Do you have any symptoms of illness today?		
If yes, please explain:		
Are you allergic to eggs or to a component of the vaccine?		
Have you ever had a serious reaction to the influenza vaccine in the past?		
Have you ever had Guillian-Barre Syndrome (GBS)		

HAMPSHIRE COUNTY HEALTH DEPARTMENT USE ONLY

Influenza
Lot # _____
R deltoid L deltoid
Nurse Initial:_____

Pneumonia – PCV13
Lot # _____
R deltoid L deltoid
Nurse Initial:_____

Hampshire County Health Department
Tamitha L. Wilkins, RN
Carolyn J. Kimble, RN
16189 Northwestern Pike
Augusta, WV 26704
Phone: 304-496-9640
Fax: 304-496-9650
NPI: 1750489415

PRIVATE PAY

AMOUNT PAID: $_____

CASH:_____ CHECK:_____ CHECK #:_____

RECEIPT ISSUED BY:_____

INSURANCE BILLING

ENTERED: Healthstat _____ INSURANCE BILL DATE:_____

WVSIIS _____ BILLED BY:_____

Location: _____