EXTERNAL CLINIC
Patient Information Sheet

Please provide a form of payment or your insurance card at time of service.

Patient Information: *(Please Print)*

Patient Name: _____

Patient Birthdate: _____ Patient Age: _____

Patient Sex: ☐ Male ☐ Female

Patient Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Hispanic ☐ Other

Patient Address:_____

City: _____ State: _____ Zip Code: _____

Patient Phone Number: _____

If ***Patient*** *is under 18 provide the following:*

Patient's Parent/Legal Guardian Name: _____

Patient's Parent/Legal Guardian Date of Birth: _____

Relationship to ***Patient***: _____

For Office Use Only

Insurance Company: _____

Policy Holder Name: _____ Policy *Holder* Birthdate: _____

Policy or Subscriber ID# _____

Policy Holder Address: _____

City: _____ State: _____ Zip Code: _____

Policy Holder relation to patient: _____

Policy Holder Phone Number: _____

Insurance Information:

My current insurance status is:

☐ Uninsured. I/my child do/does not have health insurance

☐ Insured. I/my child do/does have health insurance, and it covers all or part of the cost of immunizations.

X_____

Signature of Client (or Parent/ Guardian/ Representative) Date

HIPAA

I acknowledge receipt of a copy of the Bear River Health Department (Health Department) *Notice of Privacy Practices – For Protected Health Information (Notice)* which I have or will carefully review, and acknowledge my rights for a more complete description and understanding of the potential uses, disclosures of and/or requests for such Protected Health Information by the Health Department.

I acknowledge that the Health Department reserves for itself the right to change the terms of its Notice at any time, and that if the Health Department does not change the terms of its Notice, I acknowledge the right to obtain a copy of the current revised Notice at any Health Department office.

X_____

Signature of Client (or Parent/ Guardian/ Representative) Date

Consent for Services:

I have been provided with information about the vaccine I am receiving today. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine.

X_____

Signature of Client (or Parent/ Guardian/ Representative) Date

Are you allergic to eggs? Yes No

For Office Use Only:

Payment Method: Cash Check Charge

Employer Billing: _____

Flu Lot #: _____ Site: _____

Pneu Lot# _____ Site: _____

Nurses Initials:_____