



CLIENT INFORMATION FORM

Name (Last) \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender  Female  Male

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Residence Address \_\_\_\_\_

OPTIONAL

Ethnicity  Hispanic  Not Hispanic  Unknown Race  White  American Indian  Black  Alaskan Native  Asian  Hawaiian—Pac Islander  Other

Language  English  Spanish  Other \_\_\_\_\_ SS# (optional) \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Msg Phone \_\_\_\_\_

Parent or Guardian \_\_\_\_\_ Mother's Maiden Name \_\_\_\_\_

At birth were you a:  Single  Twin  Triplet  Other Is the patient on the WIC program?  Yes  No

Circle all that apply:\*0-18 years of age only\*

Medicaid  No Insurance  Insurance  American Indian  Alaskan Native  Underinsured

Optional: Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Primary Insurance Patient's relationship to insured:  Self  Spouse  Child

Insurance Company: \_\_\_\_\_ Name of Primary Insured: \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_ Insured Phone: \_\_\_\_\_

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's address if different from above: \_\_\_\_\_

Medicaid Information

Name (as printed on card): \_\_\_\_\_ Medicaid # \_\_\_\_\_

ALL CLIENTS PLEASE READ THE FOLLOWING AND INITIAL

\_\_\_\_\_ I acknowledge that I was given a copy, and I have read, or had explained to me the Central District Health Department Notice of Privacy Practices.

\_\_\_\_\_ I acknowledge that I was given a copy, and I have read, and understand the Financial and Appointment Policy.

\_\_\_\_\_ I need financial assistance. My household size \_\_\_\_\_ My monthly income \_\_\_\_\_

If left blank, or 0, we will automatically bill at full price.

\_\_\_\_\_ I understand that childhood immunizations are not mandatory and may be refused on religious or other grounds.

\_\_\_\_\_ Participation in and withdrawal from the Immunization Registry (IRIS) is voluntary. Call Idaho Immunization Program at 208.334.5931 to opt-out or withdraw. If you do not opt-out of IRIS in writing, your child's immunization records will be stored in the registry.

Signature of person receiving vaccine or the person authorized to make the request:

SIGNATURE X \_\_\_\_\_ DATE \_\_\_\_\_



## Medical History

The following questions will help us determine which vaccines you may be given today. If a question is not clear, please ask a health care provider to explain it.

**PLEASE MARK ANSWER**

Is the patient sick today?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Does the patient have any known allergies to medications, food, vaccine component or latex? (For example: eggs) Please list: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Has the patient ever had a serious reaction after receiving a vaccine? (Routine or Flu vaccines)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Has the patient ever had Guillain-Barre Syndrome (a type of temporary, severe muscle weakness), seizures or neurological disorders?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Does the patient have cancer, leukemia, HIV/AIDS, immune system problems, or have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Does the patient take cortisone, prednisone, other steroids, or anti-cancer drugs, or has the patient had radiation treatments? Long term aspirin therapy? Daily aspirin dose _____.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
During the <b>past year</b> , has the patient received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? If yes, when? month _____ day _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Has the patient received a MMR, Varicella, Rotavirus, or FluMist vaccine in the <b>past four weeks</b> ? If yes, when? month _____ day _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Does the patient have any of the following: asthma, wheezing, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood? Is the patient on long-term aspirin therapy?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Has the patient had chickenpox? If yes, when? _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Does your family have a dentist?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Has your child seen a dentist in the last year?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
<b>For females:</b> Are you pregnant or is there a chance you could become pregnant during the next month?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE

**Signature of person completing form:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Nurse:** \_\_\_\_\_

***I have reviewed the information above and made changes if indicated.***

Date: _____	Client/Guardian initials: _____	Nurse initials: _____
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Client Name/DOB Label