



Boise Office 707 N. Armstrong Place, Boise, ID 83704

Phone (208) 327-7450

Mountain Home Office 520 E. 8th N. Street, Mt. Home ID 83647

Phone (208) 587-4407

McCall Office 703 North 1st, McCall ID 83638

Phone (208) 630-8002

To improve the health of our communities by identifying sustainable solutions to community health issues, developing partnerships for implementation of strategies, and demonstrating our success through measurement of outcomes.

CLIENT INFORMATION (PLEASE PRINT)

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Age: _____ Gender: M or F

Mailing Address: _____ Phone Number: _____

City: _____ State: _____ Zip: _____

Email address: _____ (for reminder recall only)

Parent or Guardian name: _____
(when applicable)

Circle all that apply *Ages 0-18 yrs only*

Medicaid / No Insurance / Insurance / American Indian / Alaskan Native

FINANCIAL POLICY: Effective July 1, 2009

INSURANCE: You will be responsible for balance owing on any vaccine and administration of vaccines that the insurance does not cover. **CDHD will bill primary insurance only!**

MEDICAID: Please present your Medicaid card at check-in. Non-covered services will be your responsibility.

No childhood immunizations will be denied due to inability to pay. Please ask for information at check-in.

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# _____

FOR OFFICE USE ONLY

Payment Category:

Staff initials: _____

Cash

Credit/Debit Card

Check Number _____

3rd Party Billing Company Name _____

Slide

Please complete other side

<p align="center">SCREENING QUESTIONNAIRE FOR INJECTABLE INFLUENZA VACCINATION</p> <p>For adult patients as well as parents of children to be vaccinated.</p> <p>The following questions will help you determine if there is any reason we should not give you or your child injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.</p>	YES	NO
IS THE PERSON TO BE VACCINATED TODAY MODERATELY OR SEVERLY ILL?		
DOES THE PERSON TO BE VACCINATED HAVE AN ALLERGY TO CHICKEN EGGS OR TO A COMPONENT OF THE VACCINE?		
HAS THE PERSON TO BE VACCINATED EVER HAD A SERIOUS REACTION TO INFLUENZA VACCINE IN THE PAST?		

ALL CLIENTS PLEASE READ THE FOLLOWING AND CHECK APPROPRIATE BOXES

I give permission to enroll me or my child and to transfer my or my child's immunization records into the Idaho Immunization Reminder Information System (IRIS) to ensure that this vaccination record is available to me, or my child's health care providers, and schools. I understand I may be asked for information that will help ensure my or my child's records are accurate and will not be confused with another person's records, such as: mother's maiden name, telephone number, child's gender, and child's eligibility for free vaccine. I authorize inclusion of all information into IRIS.

- NO (do not enroll me/my child in IRIS)
- I hereby 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.
- Immunization Release of Information—This release is in effect for 1 year from date below. This release may be revoked at any time by a signed, written statement from the patient or responsible party.
- I have read or have had explained to me the information form about **influenza** vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine, and request the vaccine be given to me or to the person named for whom I am authorized to make this request.
- YES, I will be returning to CDHD for immunizations. NO, I routinely receive immunizations from my physician.

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

SIGNATURE X _____ **DATE** _____

Date _____

Nurse Signature _____

Return Date _____

(FOR NURSES USE ONLY)