Southwest Utah Public Health Department – Intake Form

All information is strictly confidential

(*Please Print*)

Today's Date: _____

CLIENT INFORMATION:

Name: _____ Mother's Maiden Name: _____
LAST FIRST MIDDLE

Address: _____
STREET/P.O. BOX CITY STATE ZIP CODE

Telephone: (_____) _____ - _____ ☐ Home ☐ Cell ☐ Message ☐ Work

Telephone: (_____) _____ - _____ ☐ Home ☐ Cell ☐ Message ☐ Work

Email: _____

Birth Date: _____ / _____ / _____ Age: _____ Gender: ☐ Male ☐ Female
MO DY YR

Race: ☐ White ☐ Black ☐ Asian ☐ Indian/American Native ☐ Native Hawaiian/Pacific Islander ☐ Other

Hispanic/Latino: ☐ Yes ☐ No

FAMILY INFORMATION (if client is a minor):

Head of Household Name: _____ ☐ Male ☐ Female
LAST FIRST MIDDLE

Address (if different from above): _____
STREET/P.O. BOX CITY STATE ZIP CODE

RESPONSIBLE PARTY/GUARANTOR: ☐ Same as Client ☐ Same as Head of Household or

Organization to bill for today's services: _____

Address: _____
STREET/P.O. BOX CITY STATE ZIP CODE

INSURANCE INFORMATION:

Medicaid/CHIP: ☐ Yes ☐ No ID Number: _____

Medicare: ☐ Yes ☐ No ID Number: _____ (Provide current HMO ID card, if applicable)

Private Insurance: ☐ Yes ☐No **We accept the following private insurance plans: Aetna, DMBA, PEHP, SelectHealth, Tall Tree including HSA, UnitedHealthCare (some exceptions)**

Insurance Co. Name: _____ ___ ID Number: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Does your insurance cover the cost of immunizations? ☐ Yes ☐ No ☐ Unknown

Please complete the reverse side of this form if receiving immunizations.

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For Health Department Use ONLY:	Gross Monthly Income: _____ # of Family Members: _____ PFR: _____ RN: _____

OVER ⇒

Immunization Screening Questionnaire

	Please answer the following questions – check all that apply	YES	NO	UNK
1	Is the individual sick today?			
2	Does the individual have allergies to medications, food or vaccine components? If yes, list _____			
3	Has the individual ever had a serious reaction after receiving a vaccine? If yes, describe_____			
4	Has the individual ever had a seizure or change in neurological status, or ever had Guillian-Barré Syndrome?			
5	Does the individual have a disease or condition that causes a weakened immune system such as diabetes, cancer, leukemia, lymphoma, HIV/AIDS or does the individual take cortisone, prednisone, other steroids or medications for rheumatoid arthritis, or had radiation treatments in the past 3 months?			
6	Is the individual, or will the individual be, at risk for blood borne infections such as HIV, AIDS, or Hepatitis B and C? Risks include: Occupational risk, blood transfusions, unprotected sexual contacts, use of shared or unsterile needles for injection of drugs or medications, tattoos, acupuncture, injections given in developing countries.			
7	During the past year has the individual received a transfusion of blood or blood products or been given a medication called immune (gamma) globulin?			
8	Is the individual pregnant or at risk of becoming pregnant within the next month or currently breastfeeding?			
9	Does the individual smoke?			
10	Has the individual received any vaccination in the past 4 weeks?			
11	**For all:** Has the individual had Chickenpox disease? **For children only:** If yes, give month _____ and year _____.			

CONSENT FOR TREATMENT AND PRIVACY NOTICE

I certify that the information I have provided is true and accurate. I have been given a copy and have read, or have had explained to me, the information contained in the important Vaccine Information Statements. I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines and request that the vaccines indicated be given to the person named above for whom I am authorized to make this request. I agree that this information may be shared with schools, day care centers, health care providers and others when deemed medically necessary. I HEREBY RELEASE SOUTHWEST UTAH PUBLIC HEALTH DEPARTMENT, AND ITS EMPLOYEES, FROM ALL CLAIMS ARISING FROM SUCH IMMUNIZATIONS.

We are required to inform you of our privacy practices for the information we collect and keep about you. I have been given a copy of the Health Department's Notice of Privacy Practices and have had an opportunity to ask questions about how my information may be used.

Signature: _____ Today's Date: _____

Relationship to Client: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Other _____