



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, Educators

Mutual, Select Health, Tall Tree including HSA, United Health (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.

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