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
Are you 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, Cigna, DMBA, EMI, Healthy Premier,
Motiv Health, PEHP, Select Health, Tall Tree, 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.

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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.

I UNDERSTAND THE BILLING OF MEDICAL INSURANCE DOES NOT GUARANTEE PAYMENT AND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCE.

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 _____