

Southwest Utah Public Health Department – Intake Form

All information is strictly confidential (PLEASE PRINT).

CLIENT INFORMATION:

Today's date _____

Name: _____ Mother's Maiden Name: _____
Last First Middle

Address: _____
Street / P.O. Box City State Zip Code

Telephone: (_____) _____ - _____ Circle one: Home Cell Message Work
Telephone: (_____) _____ - _____ Circle one: Home Cell Message Work

Birth Date: ____ / ____ / ____ Age: _____ Gender: Male Female
M D Yr

Race: White Black Asian Other
 Indian/Am. Native Native Hawaiian/Pacific Islander

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 Head of Household

Organization/Person to bill for today's services: _____

Address: _____
Street / P.O. Box City State Zip Code

Please complete below:

Medicaid: Yes No ID Number: _____

Medicare: Yes No ID Number: _____

Private Insurance: Yes No Insurance Co: _____
If yes, subscriber's name: _____ Subscriber's date of birth _____

Does your insurance cover the cost of immunizations?
Yes No Don't know

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

For Health Department Use ONLY:

Gross Monthly Income: _____ # Family members: _____
PFR: _____ RN Initials: _____

Please complete the following questionnaire.

Immunization Screening Questionnaire			
Check all boxes that apply	Yes	No	Unk.
1. Is the individual sick today?			
2. Does the individual have allergies to medications, food or vaccines?			
3. Has the individual ever had a serious reaction after receiving a vaccine?			
4. Has the individual had a seizure or change in neurological status, or has ever had Guillian-Barré Syndrome?			
5. Does the individual have a disease or condition that causes a weakened immune system such as cancer, leukemia, lymphoma or HIV/AIDS?			
6. Does the individual take cortisone, prednisone, other steroids or medications for rheumatoid arthritis, or had radiation treatments in the past 3 months?			
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. For Women: Is the individual pregnant or at risk of becoming pregnant within the next month?			
9. Has the individual received any vaccination in the past 4 weeks?			
10. For all: Has the individual had Chicken Pox 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 information Statement(s) or Vaccine Information Sheet(s) about the disease(s). I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) 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 THE SOUTHWEST UTAH PUBLIC HEALTH DEPARTMENT, AND THEIR 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: _____ Date: ___ / ___ / ___
M D Yr

Relationship to Client: Self Parent Legal Guardian Other_____