Tippecanoe County Health Department
629 N 6th St Suite A
Lafayette, IN 47901-1211
765-423-9222

NPI: 1189-182-391

PATIENT INFORMATION:

Patient Name: _____Mother's Maiden Name: _____

Street Address: _____ Apt. #: _____ City: _____ State: _____ Zip: _____

Phone - Home: _____ Cell: _____ E-mail: _____

Date of Birth: ____/____/_____ Patient Sex: ☐Male ☐Female Race: _____ Ethnicity: ☐Non-Hispanic ☐Hispanic

Parent/Guardian Name: _____

How did you hear about us? ☐Walk-in/TCHD Staff ☐Billboard ☐Bus ☐Doctor's Office ☐Other _____

Is the patient covered by health insurance? ☐Yes ☐No **IF YES, COMPLETE THE INSURANCE INFORMATION BELOW**

INSURANCE INFORMATION: ☐Medicaid ☐ ☐Medicare ☐Private Insurance

Medicaid #: _____ Medicare ID #_____

Insurance Company Name: _____ Policy Holder *(Insured's Name)*: _____

Policy Holder's Date of Birth ____/____/_____ Member ID: _____ Group Number: _____

Insured's relationship to the patient: ☐Parent/Guardian ☐Spouse ☐Self ☐Other: _____

HEALTH HISTORY:

1.	Are you allergic to any foods or medicines? (eggs, gelatin, Penicillin, latex)	☐Yes	☐No
2.	Have you ever had an allergic reaction or other problem after a vaccination?	☐Yes	☐No
3.	Have you ever had a SEIZURE or Guillain-Barre Syndrome?	☐Yes	☐No
4.	Do you feel well today?	☐Yes	☐No
5.	Do you have a long-term health problem, such as heart disease, lung disease (e.g. asthma)? kidney disease, metabolic disease (e.g. diabetes) or a blood disorder?	☐Yes	☐No
6.	Do you have a weakened immune system because of HIV/AIDS or other disorder? long-term treatment such as steroids or cancer treatment with x-rays or drugs?	☐Yes	☐No
7.	Do you live with or have close contact with anyone with severely weakened immune? requiring care in a protected environment?	☐Yes	☐No
8.	Do you take aspirin or another salicylate medication?	☐Yes	☐No
9.	Have you received any vaccine in the <u>past 4 weeks</u>?	☐Yes	☐No
10.	Are you pregnant or could become pregnant within the next month?	☐Yes	☐No
11.	Would you like <u>FLU</u> vaccination today?	☐Yes	☐No
12.	Are you taking any medications currently?	☐Yes	☐No

<u>CONSENT TO TREAT</u>: I authorize the TIPPECANOE COUNTY HEALTH DEPARTMENT to administer treatment as deemed necessary for care of the patient named above. I certify that I am the patient, parent or legal guardian of the patient. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the treatment.

<u>FINANCIAL RESPONSIBILTY:</u> I understand that I am financially responsible for all charges not covered by insurance.

<u>ASSIGNMENT OF BENEFITS</u>: All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. The patient/parent/responsible party is responsible for any unpaid balances. Co-Payments will be made at the time of service. I request that payment of authorized Medicare, Medicaid, or other insurance company benefits be made to TIPPECANOE COUNTY HEALTH DEPARTMENT for any services furnished to me by the Tippecanoe County Health Department. Regulations pertaining to Medicare and Medicaid assignment of benefits apply.

<u>NOTICE OF PRIVACY PRACTICES</u>: I acknowledge that I have been given an opportunity to read the Notice of Privacy Practices for the Tippecanoe County Health Department and to have any questions answered before signing.

My signature indicates agreement to the above and that all information provided above is true and accurate:

_____ _____

Signature of Patient or Legal Representative *Date*

Staff Use Only: Reviewed by:_____RN Date_____/_____/_____ Rev. 4/2019

Staff Use Only:

☐Medicaid ☐Medicare ☐Private Insurance ☐American Indian/Alaskan Native ☐Underinsured ☐No Insurance

Immunization Administration		
		PROCEDURE CODE
☐	Immunization admin., 1 vaccine (single or combination vaccine/toxoid)	90471
☐	each additional vaccine (single or combination vaccine/toxoid)	90472
☐	Immunization admin. by intranasal or oral route, 1 vaccine (single or comb. vaccine/toxoid)	90473
☐	each additional intranasal or oral vaccine administration (single or combination vaccine/toxoid)	90474

☐	VACCINE PRODUCT	VACCINE COMPONENTS	MAN./LOT #	ROUTE/ SITE	CPT
☐	**ActHIB**	Hib VIS 4/2/15			90648
☐	**Adacel/Boostrix**	Tdap VIS 2/24/15			90715
☐	**Daptacel/Infanrix**	DTaP VIS 8/24/18			90700
☐	**Engerix – B** Adult, 20+ Years	HepB VIS 10/12/18			90746
☐	**Engerix – B** Birth – 19 Years	HepB VIS 10/12/18			90744
☐	**Flurix Quad** 6mon + years	Influenza VIS 8/7/15			90686
☐	**Gardasil 9**	HPV9 VIS 12/2/16			90651
☐	**Havrix** Pediatric/Adolescent	Hep A VIS 7/20/16			90633
☐	**Havrix**, Adult	Hep A VIS 7/20/16			90632
☐	**IPOL**	IPV VIS 7/20/16			90713
☐	**Kinrix**,	DTaP – IPV			90696
☐	**MMR II**	Measles, mumps, rubella VIS 2/12/18			90707
☐	**Menveo/Menactra**	Mening VIS 8/24/18			90734
☐	**Pediarix**	DTaP – HepB – IPV			90723
☐	**PedvaxHIB**	Hib VIS 4/2/15			90647
☐	**Pentacel**	DTaP–Hib–IPV			90698
☐	**Prevnar13**	Pneum VIS 11/5/15			90670
☐	**ProQuad**	MMR-V VIS 2/12/18			90710
☐	**Rotateq**	Rotavirus VIS 2/23/18			90680
☐	**Rotarix**	Rotavirus VIS 2/23/18			90681
☐	**Td**	Tetanus VIS 4/11/17			90718
☐	**Tenivac**,	Tetanus VIS 4/11/17			90714
☐	**Twinrix**	HepA–HepB			90636
☐	**VAQTA** 0-18 Years	HepA VIS 7/20/16			90633
☐	**VAQTA** 19+ Years	Hep A VIS 7/20/16			90632
☐	**Varivax**	Varicella VIS 2/12/18			90716
☐	**Trumenba/Bexro**	MenB VIS 8/9/16			90620
☐	**Typhim Vi**	Typhoid 05/29/2012			90691
☐	**YF-VAX**	Yellow Fever 3/30/2011			90717
☐	**LEAD**	Assay of lead, using filter paper			83655

Total Charge_____ **Total Payment**_____ **Date VIS provided** _____