Clear Form

galion city HEALTH DEPARTMENT

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Patient Health & Immunization History

Patient's Last Name: _____ First Name: _____ Middle: _____

Birth Date: _____ Age: _____ ☐ Male ☐ Female Your Relationship to Patient: _____

Current Weight: _____ Has the patient previously received vaccinations at the Galion City Health Department? ☐ No ☐ Yes

Insurance Status (List **ALL** current policies):

☐ I have Medicaid. Carrier: _____ Billing #/ID #: _____

☐ I have private insurance. Carrier: _____ Insured's Name: _____

Insured's Birth Date: _____ Billing #/ID #: _____ Group #: _____

Insured's Address (if different from patient): _____

Insured's Phone (if different from patient): _____ Does this insurance cover shots? ☐ Yes ☐ No

☐ I don't have health insurance.

Has **ANY** insurance information changed since your last visit, including the carrier, ID #s, etc.? ☐ Yes ☐ No

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1. Does the patient have allergies or has he/she had an adverse reaction to medications, vaccines, food, or latex? ☐ No ☐ Yes, please explain: _____
2. Is the patient taking any medication at this time? ☐ No ☐ Yes, please explain: _____
3. Is the patient sick today or had a fever in the last 24 hours? ☐ No ☐ Yes, please explain: _____
4. Is the patient diagnosed with chronic illnesses like lung, heart, or kidney problems, diabetes, asthma, or blood disorders? ☐ No ☐ Yes, please explain: _____
5. Has the patient ever had a seizure or has the patient had brain or other nervous system problems? ☐ No ☐ Yes, please explain: _____
6. Does the patient have cancer, leukemia, AIDS, or any other immune system problem? ☐ No ☐ Yes
7. Has the patient taken steroids such as prednisone or anticancer drugs including radiation within the last 3 months? ☐ No ☐ Yes
8. Has the patient received blood, blood products, or Gamma Globulin in the past 6 months? ☐ No ☐ Yes
9. Has the patient ever had chickenpox? ☐ No ☐ Yes Has the patient ever received the chickenpox vaccine? ☐ No ☐ Yes
10. Has the patient received any vaccinations in the past 4 weeks? ☐ No ☐ Yes
11. Has the patient received vaccines elsewhere since their last visit here? ☐ No ☐ Yes, where: _____
12. For **female** patients: Is there any chance of pregnancy or chance she may become pregnant in the next month? ☐ No ☐ Yes

I have received a copy of the Vaccine Information Statement(s) regarding the diseases and vaccines. I grant permission for requested vaccine(s) to be given today. I understand that this information will be released to a state-wide immunization registry for immunization tracking, recall, and recording; unless I request otherwise. I understand that the patient should remain in the office for 15 minutes for observation in case of an adverse reaction.

If insurance is checked above, I authorize the Galion City Health Department to submit claims to my insurance company. I authorize payment of medical benefits to the Galion City Health Department for services administered. I further understand that I am responsible for any co-pays, co-insurance, deductibles, and/or non-covered charges as determined by my insurance carrier.

Signature: _____ Date: _____

For Health Department Use Only: ☐ **Public/VFC** ☐ **Private** Return Appointment Needed? ☐ Yes ☐ No

☐ DTap	☐ Varicella	☐ Pneumococcal	☐ Meningitis	☐ Kinrix/Quadracel (DTP, IPV)	☐ Pediarix (DTP, Hep B, IPV)
☐ IPV	☐ MMR	☐ Hepatitis B	☐ HPV	☐ Pentacel (DTP, IPV, HIB)	☐ ProQuad (MMR, Varicella)
☐ HIB	☐ Rotavirus	☐ Tdap/Td	☐ Hepatitis A	☐ Other: _____	