



CLIENT INFORMATION FORM

CLIENT DEMOGRAPHIC INFORMATION

PATIENT # _____

Date of Birth ____/____/____ Age ____ SS# (optional) _____

Name (First) _____ Middle _____ Last _____

Mailing Address _____

Zip _____ City _____ State _____

Home Phone _____ Work Phone _____ Cell Phone _____

Optional: Email _____ Texting Number Yes No

Gender Female Male At birth were you a: Single Twin Triplet Other

Race White American Indian Black Alaskan Native Asian Hawaiian—Pac Islander Other Ethnicity Hispanic Not Hispanic Unknown

Language English Spanish Other _____ Limited English Proficiency Yes No

Mother's Maiden Name _____ Client Alias _____

PARENT/GUARDIAN INFORMATION Mother - Father - Other _____

SS# (optional) _____

Name (First) _____ Middle _____ Last _____

Mailing Address _____ City _____ State _____ Zip _____

Date of Birth ____/____/____

PRIMARY INSURANCE None Patient's relationship to insured: Self Spouse Child

Insurance Company: _____ Name of Primary Insured: _____

Insured Date of Birth: _____ Insured Phone: _____

ID#: _____ Group #: _____

Insured's address if different from above: _____

MEDICAID INFORMATION

Name (as printed on card): _____ Medicaid # _____

ALL CLIENTS PLEASE READ THE FOLLOWING AND INITIAL

_____ I acknowledge that I was given a copy, and I have read, or had explained to me the Central District Health Department Notice of Privacy Practices.

_____ I acknowledge that I was given a copy, and I have read, and understand the Financial and Appointment Policy.

_____ I need financial assistance. My household size _____ My monthly income _____

Monthly gross income (DO NOT LEAVE BLANK, DO NOT ENTER 0)

_____ I understand that childhood immunizations are not mandatory and may be refused on religious or other grounds.

_____ Participation in and withdrawal from the Immunization Registry (IRIS) is voluntary. Call Idaho Immunization Program at 208.334.5931 to opt-out or withdraw. If you do not opt-out of IRIS in writing, your child's immunization records will be stored in the registry.

Signature of person receiving vaccine or the person authorized to make the request:

SIGNATURE X _____ DATE X _____



Medical History

The following questions will help us determine which vaccines you may be given today. If a question is not clear, please ask a health care provider to explain it.

PLEASE MARK ANSWER

Is the patient sick today?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Does the patient have any known allergies to medications, food, vaccine component or latex? (For example: eggs) Please list: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Has the patient ever had a serious reaction after receiving a vaccine? (Routine or Flu vaccines)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Has the patient ever had Guillain-Barre Syndrome (a type of temporary, severe muscle weakness), seizures or neurological disorders?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Does the patient have cancer, leukemia, HIV/AIDS, immune system problems, or have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Does the patient take cortisone, prednisone, other steroids, or anti-cancer drugs, or has the patient had radiation treatments? Long term aspirin therapy? Daily aspirin dose _____.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
During the past year , has the patient received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? If yes, when? month _____ day _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Has the patient received a MMR, Varicella, Rotavirus, or FluMist vaccine in the past four weeks ? If yes, when? month _____ day _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Does the patient have any of the following: asthma, wheezing, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood? Is the patient on long-term aspirin therapy?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Has the patient had chickenpox? If yes, when? _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Does your family have a dentist?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Has your child seen a dentist in the last year?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
For females: Are you pregnant or is there a chance you could become pregnant during the next month?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE

Circle ALL that apply:
 Medicaid / No Insurance / Insurance / American Indian / Alaskan Native / Underinsured

I have received the vaccine information statement (s) for vaccines being administered at this visit. I understand the benefits and risks of the vaccine (s) and request that they be administered to me or my child as authorized by the signature below.

I've been informed about the circled vaccines and I choose not to have my child/self vaccinated with them today.
 Dtap / Flu / Hep A / Hep B / HIB / HPV / Meningitis / MMR / PCV 13 / Polio / Rotavirus / Tdap / Varicella

_____ Yes, the patient will return to CDHD for immunizations _____ No, the patient will return to their physician for immunizations
Signature of person completing form: _____ **Date:** _____ **Nurse:** _____

I have reviewed the information above and made changes if indicated.

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