WEB IZ LABEL

PATIENT INFORMATION (PLEASE PRINT – USE ONLY INK):

☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Living together ☐ Life Partner

Patient Name: (Last) ______________________________ (First) ____________________________ (Middle):____________

Social Security: _______________________ ☐ Female ☐ Male Date of Birth: _________________ Age: ________

Home Address: _________________________________ City:________________ State________ Zip Code__________

Primary Phone: ___________________ May we text you? ☐ Yes ☐ No Email: ______________________________

PRIMARY CARE PHYSICIAN NAME/PHONE NUMBER (Cigna Members Only): ____________________________________

DO YOU HAVE HEALTH INSURANCE? ☐ Yes ☐ No Do you have other Insurance besides **MEDICAID?** ☐ Yes ☐ No

RESPONSIBLE PARTY: (Complete this section only if the patient is a minor): ☐ Parent ☐ Guardian

(Last Name): _________________________________ (First): _________________________________ (Middle): ____________________

☐ Female ☐ Male Date of Birth: ______________________________ Primary Phone: _____________________________

Home Address: ____ City:_________________ State_____________ Zip Code_________

☐ Student ☐ Employed ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer ____ Occupation: ____

PRIMARY INSURANCE: Relation to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Insurance Co. ________________________________ Id # ____________________________ Group #: __________________

Name of Insured: ______________________________ Date of Birth: ____________________ Social Security: _____________

Employer: ______________________________________ Occupation: ____________________________________

☐ Same As Above (If different, please complete):

Home Address: ____ City: ______________ State_______ Zip Code__________

SECONDARY INSURANCE: Relation to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Insurance Co. ________________________________ Id # ____________________________ Group #: __________________

Name of Insured: ______________________________ Date of Birth: ____________________ Social Security: _____________

Employer: ______________________________________ Occupation: ____________________________________

☐ Same As Above (If different, please complete):

Home Address: ____ City: ______________ State_______ Zip Code__________

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I certify that the above information is correct to the best of my knowledge. I hereby authorize SNHD to furnish the insured's insurance company all information which said insurance company may request concerning the present services rendered. I assign SNHD all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions. I will notify SNHD in writing of any change in my or my minor child's insurance coverage. This authorization shall continue and be in full force and effect until revoked in writing by me.

_______________________________________ _____________ _____________

Patient (or Responsible Party) Signature **Date** **SNHD Initials**

Vaccine Administration Record & Informed Consent

Patient's Name____

Last First Middle

Gender: ☐ Male ☐ Female **Birth Date**:________________ **Age**:________

Race: ☐ Caucasian ☐ Black or African American ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Unknown or not reported

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Do you have insurance: ☐ No ☐ Yes **If yes, type:**________________________________

If your child has Nevada Medicaid or Nevada Check-Up, would you like a free children's exam? ☐ **No** ☐ **Yes**

VFC Eligibility (Clerk use only):
☐ Not Eligible ☐ No Insurance ☐ Underinsured ☐ Native American or Alaskan Native ☐ NV Medicaid ☐ NV Check-Up

Did you bring your or your child's immunization record today? ☐ **No** ☐ **Yes**

PLEASE NOTE: *It is important for you to have a personal record of your vaccinations. If you don't have a record, ask your health care provider to give one to you. Bring this record with you every time you seek medical care. Make sure your health care provider records all your vaccinations on it. Your child will need this record to enter childcare, kindergarten, college, etc.*

The following questions will help us to determine which vaccines may be given today. If a question is not clear, please ask the nurse to explain it:

IS THE PERSON RECEIVING THE VACCINE…	**Yes**	**No**	**Don't Know**
1. Sick today?	☐	☐	☐
2. Allergic to latex, medications, food or any vaccine?	☐	☐	☐
3. Ever had a serious reaction after receiving a vaccine?	☐	☐	☐
4. Had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	☐	☐	☐
5. Between the ages of 2 and 4 years and had a healthcare provider tell you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. Been diagnosed with cancer, leukemia, AIDS or any other immune system problem?	☐	☐	☐
7. Taking cortisone, prednisone, other steroids, anticancer drugs or x-ray treatments?	☐	☐	☐
8. Been given a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin during the past year?	☐	☐	☐
9. Had a seizure or a brain problem?	☐	☐	☐
10. Received any vaccinations or TB skin tests in the past four (4) weeks or been told to get a TB skin test?	☐	☐	☐

FOR GIRLS/WOMEN 9 years old or older:			
Are you pregnant?	☐	☐	☐
Are you trying to get pregnant in the next 28 days?	☐	☐	☐
Counseled to avoid pregnancy within the next 28 days: Nurse initial __________ / Client initial __________	☐	☐	☐

Informed Consent*:* *I have read or have had explained to me the information contained in the Vaccine Information Statement(s) about the disease(s) and the vaccine(s). I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated on the reverse side be given to me or to the person named above for whom I am authorized to make this request.*

Signature of: ☐ Client (18 years of age and older) ☐ Parent or ☐ Guardian

SIGN HERE: ______________________________________ **Date:** ____________________

COMPLETE THE TOP PART ON THE BACK (NAME AND DATE OF BIRTH ONLY) ➔

Patient's Name______________________________ **Birth Date**__________________

Last First Month Day Year

Vaccine	Date Given	Dose #	Mfg & Lot #	Site	Route	VIS Date	Administered by (Name/Title)
AREA BELOW FOR SNHD STAFF ONLY							
DTaP				LA RA LT RT	IM	05-17-07	
DT				LA RA LT RT	IM	05-17-07	
Td				LA RA LT RT	IM	02-24-15	
Tdap Adacel Boostrix				LA RA LT RT	IM	 02-24-15 02-24-15	
IPV				LA RA LT RT	IM SQ	11-08-11	
HIB Ped Vax Act hib				LA RA LT RT	IM	 04-02-15 04-02-15	
MMR				LA RA LT RT	SQ	04-20-12	
Varicella				LA RA LT RT	SQ	03-13-08	
MMRV				LA RA LT RT	SQ	05-21-10	
Hep A				LA RA LT RT	IM	10-25-11	
Hep B				LA RA LT RT	IM	02-02-12	
Hep A/Hep B **Twinrix**				LA RA LT RT	IM	10-25-11 02-02-12	
Meningococcal **Menveo, Menactra** **Menomune** **MenB**				LA RA LT RT	IM SQ	 03-31-16 10-14-11 08-14-15	
PCV13				LA RA LT RT	IM	11-05-15	
DTaP/IPV Ki**nrix**				LA RA LT RT	IM	05-17-07 11-08-11	
DTaP/IPV/HIB **Pentacel**				LA RA LT RT	IM	05-17-07 11-08-11 04-02-15	
DTaP/IPV/Hep B **Pediarix**				LA RA LT RT	IM	05-17-07 11-08-11 02-02-12	
Pneumococcal **Pneumovax**				LA RA LT RT	IM SQ	 04-24-15	
Rabies				LA RA LT RT	IM	10-06-09	
Rotavirus **Rotateq** **Rotarix**				ORAL	PO	 04-15-15 04-15-15	
Flu				LA RA LT RT	IM IN	08-07-15	
Shingles **Zostavax**				LA RA LT RT	SQ	 10-06-09	
Gardasil 4 **Gardasil9**				LA RA LT RT	IM	05-17-13 03-31-16	
Smallpox				LA RA LT RT	ID		
Typhoid				LA RA	IM	05-29-12	
Yellow Fever				LA RA	SQ	03-30-11	
Newborn Screening							
Multi-Vaccine VIS						11-05-15	

Record # ________________ Return Date: ______________ VIS Given ______________ ____________________

Clerk Clinician

Clinic Location: ☐ Main ☐ ELV ☐ Hend ☐ Mesquite ☐ ____________

Reviewed by: ______________________________ RN / LPN Date: ____________________