DATE OF SERVICE: ________________ **CLIENT REGISTRATION FORM**

SAN JUAN BASIN
public health

ADULTS: Ages 19-up	**CHILDREN: Ages 0-18 yrs**
_____**I have Medicare Part B** **Medicare Number:**__________________________ **Signature**________________________________ _____I do not have Insurance that covers vaccinations _____**I DO have insurance that covers vaccines** Name of insurance:____________________________	_____My child has health insurance that covers vaccines SJBHD can bill ____CHP & ____Rocky Mountain Health Plans Policy #____________________ _____My child has other insurance, so I will pay today & submit receipt for reimbursement _____My child does not have health insurance that covers vaccinations _____My child is on MEDICAID #______________ _____My child is Native American/Alaskan Native

Patient Information:

Last Name _______________________First Name ________________Middle_____________ Maiden/Former: _____________

Date of Birth: _________/_______/________ (mm/dd/yyyy) Age: _______ Gender: **M** **F** Approx. Weight:___________

Patient Telephone: Home (____) _________________ Cell (____) __________________ Work (____) ___________________

Patient Mailing Address or PO BOX: ____

City____________________ State __________County__________________Country____________Zip Code______________

SSN (last 4) __________ Allergies: ____

Emergency Contact

Last Name_________________ First Name_______________ Phone (____)_____________ Relationship Type_____________

FOR OFFICE USE:

Pay Codes: (PB) PUBLIC= VFC; (SP) SPECIAL PROJECTS 317; & (PP) PRIVATE PAY

Vaccines Administered Today	Pay Code PB,SP,PP	Lot Number	Body Site: LA,LD,RA,RD,LL LAT,LLT,RL,RT, RLT,PO,NASAL	Dose:	Route: INTRADERMAL INTRAMUSCULAR,SUB CUTANEOUS NASAL,ORAL	RN(signature or initials)	Doses entered into CIIS
		Lot#					
		Lot#					
		Lot#					
		Lot#					
		Lot#					
		Lot #					
		Lot #					
		Lot#					

Admin Initials_____________ **Entered in CIIS**____________________ **Enter ACCESS**___________________

Date of Service: ______________________________

Name: ______________________________________

SAN JUAN BASIN
public health

Screening Questionnaire

	Yes	No	Not Sure
1. Do you have a moderate or severe illness today? Any fever?	____	____	____
2. Do you have allergies to food, medication?	____	____	____
3. Have you received any vaccinations in the past 4 weeks?	____	____	____
4. Have you/your child ever had a serious reaction to a vaccine in the past?	____	____	____
5. Do you have a history of Guillain-Barre syndrome?	____	____	____
6. Do you have an organ transplant, cancer, leukemia, HIV/AIDS, or immune system deficiency?	____	____	____
7. Are you taking immunosuppressive medicines/oral steroids >14days, or cancer treatment in the last 3 months?	____	____	____
8. Are you taking Acyclovir or any other antiviral medication?	____	____	____
9. Are you on any medications to prevent blood clotting?	____	____	____
10. Do you have a gastrointestinal disease?	____	____	____
11. Females: Are you pregnant or are you planning to become pregnant during the next month?	____	____	____

PLEASE READ: It is important to have a personal record of vaccinations and to bring this record with you every time you seek medical care or when you intend to get vaccinated. Make sure your health care provider records all your vaccinations on this record. You may need this record periodically throughout your lifespan. Duplicate copies $5.00; Duplicate International Immunizations Record $25.00