ExpressHEALTH Clinic

Today's Date	Are you a New Patient ☐ YES ☐ NO	Insurance Name: or ☐ Self-Pay

SECTION 1 PATIENT INFORMATION

Patient Full Legal Name (First) (Middle) (Last)	Date of Birth	Age	Sex ☐ Male ☐ Female

Address (Number) (Street) (Apt. No.)

City	State	Zip	Phone (Home)	Phone (Cell)

Social Security No:	Marital Status	Occupation

Emergency Contact Name ('ER Contact')	Relationship:	Contact Phone	Circle information that may be shared with ER Contact: All Medical Financial None

---IF THE FINANCIALLY RESPONSIBLE PARTY IS NOT THE PATIENT, complete the following Information---

The Following Responsible Party is the "Guarantor" and is responsible for the cost of services to the Patient:

Full Legal Name	Date of Birth:	Social Security No		Relationship to Patient	
Address (if different than Patient):	City	State	Zip	Phone (Home)	Phone (Cell)

---Complete the following regarding the Insurance cardholder if other than Patient or Responsible Party---

Full Legal Name	Date of Birth	Social Security Number

SECTION 2 VACCINATION – check each that applies

☐ Influenza (FLU)

Influenza Questionnaire

Do you have an allergy to any of the following:		
Chicken	☐ Yes	☐ No
Eggs	☐ Yes	☐ No
Latex	☐ Yes	☐ No
The preservative Thimerosal	☐ Yes	☐ No
Do have a history of adverse reaction to flu or any other vaccine	☐ Yes	☐ No
Are you ill or have a fever today	☐ Yes	☐ No
Do you have a bleeding disorder or currently taking blood thinners	☐ Yes	☐ No
Have you been paralyzed with Guillain-Barre Syndrome of have an active neurological condition	☐ Yes	☐ No
Are you pregnant or think you may become pregnant	☐ Yes	☐ No

☐ Pneumonia

Pneumonia Questionnaire

Are you taking any of the following :		
Medicine that suppresses the immune system	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Radiation	☐ Yes	☐ No
Have you ever had a Pneumonia vaccine	☐ Yes	☐ No
Have you had a Pneumonia vaccine in the last 5 years *	☐ Yes	☐ No
Are you ill or have a fever today	☐ Yes	☐ No

*Please note, if you have had a Pneumonia vaccine in the last 5 years you are not eligible for the vaccine at this time.

☐ Tetanus

☐ Tetanus Toxoid	☐ dT-Tetanus/Diptheria	☐ TDaP-Tet/Dipt/Pertusis

☐ PPD-Tuberculin Exposure Test

Have you ever had a positive TB skin test	☐ Yes	☐ No

SECTION 3 CONSENT FOR VACCINATION

I have read or have had explained to me written information about the vaccine listed above. I have had an opportunity to ask questions that were answered to my satisfaction. I understand the potential side effects that could occur such as nausea, vomiting, chills, aching, headache, flu-like symptoms or possible anaphylactic reactions that could result in death. I fully release ExpressHEALTH Clinic/the clinical staff/owners/employees from any liability for illness, injury or loss that may result from receiving this vaccination. I understand that ExpressHealth Clinic is a separate health care entity and is independent of other entities. **I understand the benefits and risks of the vaccine being administered and authorize the administration of the vaccine to me or to the person named above for whom I am authorized to make this decision.**

Signature	Date

Relationship to Patient

Initial	**I understand that any patient receiving a vaccine must remain at Express Health Clinic for at least 20 minutes after, in case a complication arises.**