CENTRAL UTAH PUBLIC HEALTH DEPARTMENT-IMMUNIZATION FORM

BIRTH DATE _____/_____/_____ Visit Date _____/_____ /_____

Patient's Name _____

Patients Mother's Maiden Name: _____

Age _____ Race _____ Sex M F Phone Number (_____) _____-_____

Parent or Guardian_____

Mailing Address_____ City, State, Zip _____

Name of Insurance_____ Name of Insured_____

Birth Date of Insured _____ Relation to Insured: _____

Policy #: _____ Group #_____

E-mail address _____

Notice of Privacy Practices and Acknowledgement of Receipt Effective April 14, 2003

The notice of Privacy Practices tell you how CUPHD may use or disclose information about you. Not all situations will be described. CUPHD is required to inform you of our privacy practices for the information we collect and keep about you. **I have been given a copy of CUPHD's Notice of Privacy Practices and have had a chance to ask questions about how information can be used. INITIALS: _____**

RISK OF WOMEN OF CHILD BEARING AGE RECEIVING RUBELLA OR VARICELLA VACCINE:

I understand the risk to an unborn in the event that I should become pregnant within one month of receiving rubella or varicella vaccine. I assume personal responsibility to prevent becoming pregnant for one month following rubella or varicella vaccine.
Initials: _____

I have been given a copy and have read, or have had explained to me, the information contained in the Vaccine Information Statement(s). I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated on this page be given to me or to the person for who I am authorized to make the request. I agree that the information on this form may be shared with schools, daycare centers, health care providers and others to verify immunization status, for public health studies, or when medically necessary. I hereby release the CUPHD to bill Medicaid, Medicare & Insurance. **I understand if my insurance provider fails to cover the cost of the immunization, I will be responsible for these services.**

Signature _____ Date _____ Relationship to Patient _____

North Sanpete	South Sanpete
Juab	Wayne
Piute	Sevier
East Millard	West Millard

*****************FOR OFFICE USE ONLY*****************

PAYMENT SECTION

Total Charge: _____

Amount Received: _____

Total Owing: _____

Receipt #: _____

VFC Eligibility: (circle one)

Medicaid	Native American	Native Alaskan
Uninsured	Underinsured	CHIP

CASH	CHECK	CREDIT CARD
MEDICAID	MEDICARE	PCN
CHIP	INSURANCE	CONTRACT

Allergies:_____

_____

Comments:_____

_____

Nurse/Provider: _____

Employee Signature:

BILL ORGANIZATION: _____

ORG. ADDRESS: _____

_____

CHECK IN _____ USIIS:_____

PAYMENT: _____ COMPUTER: _____