IMMUNIZATION INTAKE

NO ASIIS RECORD ☐

MOHAVE COUNTY DEPARTMENT OF PUBLIC HEALTH

CHILD'S FIRST NAME:	MI:	LAST NAME:	CHILD'S SSN:	DATE OF BIRTH:	AGE:

ADDRESS:	APT #:	MALE	FEMALE

CITY:	STATE:	ZIP:	TELEPHONE:

NAME OF GUARDIAN:	RELATIONSHIP:	Email:

√ (Check) the one that applies:

☐ Kids Care ☐ On AHCCCS, Medicaid, or CMDP #_____

☐ Underinsured ☐ No Insurance ☐ Native American or Alaskan Native

☐ Insurance *Policy Holder Name:_____ SSN:_____

Race:

☐ White
☐ Black
☐ Asian
☐ Native American
☐ Hawaiian/Pacific Islander

Ethnicity:

☐ Hispanic/Latin
☐ Non-Hispanic

How did you hear about our immunization clinic?

☐ received postcard ☐ doctor referral ☐ returning patient

☐ phone call ☐ school referral ☐ other_____

Do you plan to return to the Health Dept for this child's next immunizations? Yes ☐ No ☐

ASSIGNMENT OF BENEFITS: I give my consent to verify/and/or bill my insurance for the service provided. I hereby assign to the Health Department any insurance or other third-party benefits available for health care services provided to me. I understand that the County Health Department has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Mohave County Health Department, I agree to forward the County Health Department all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.

I agree to allow the health care provider giving vaccinations consent to release information about all vaccinations given to the person for whom I am authorized to consent, to the Arizona State Immunization Information System (ASIIS), other health care providers and schools in order to avoid receiving unnecessary vaccinations and to provide information about which immunizations have been received. I understand that I am not required to agree to the release of this information in order to receive the vaccinations I request.

I have been given a copy and have read, or have had explained to me, the information in the "Important Information Statement(s)" for the disease(s) and vaccine(s) checked below. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines requested, and ask that the vaccine(s) checked below be given to the person named above for whom I am authorized to make this request. I have received a copy of Mohave County Department of Public Health , Nursing Division, Notice of Privacy Practice.

*By signing below you are agreeing to all of the statements listed above.

Patient/Parent Signature_____ Printed Name_____ **Date**_____

updated 02/12/2018 CL