

Site: \_\_\_\_\_

# High Dose Flu Vaccine 65 Years and Older

1. Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

2. Date of Birth \_\_\_\_\_

3. Race:  White  Black  Am. Ind. /Alaskan Native  Asian/Pacific Islander

4. Sex:  Male  Female Ethnicity: Hispanic Origin?  Yes  No

Mother's Full Maiden Name \_\_\_\_\_

**PLEASE COMPLETE MAILING INFORMATION IF DIFFERENT ON ID**

5. Address \_\_\_\_\_

6. Telephone Number \_\_\_\_\_ (during the day)

- Medicare
- Aetna Medicare
- BCBS Medicare
- UHC Medicare
- Humana
- Medicaid
- UHC
- No Ins
- Aetna
- BCBS
- Cigna
- Health Choice
- Tricare (need policyholder ssn#)

For Health Dept Use Only

Amount Paid \$ \_\_\_\_\_

NO INS CARD

**For adult patients 65 or over to be vaccinated:** The following questions will help us determine if there is any reason we should not give you injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Are you 65 or over?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any allergies? If so, please list: <div style="border: 1px solid black; height: 20px; width: 450px; margin-top: 5px;"></div>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have an allergy to eggs or to a component of the vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had a serious reaction to influenza vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**STATEMENT OF PERMISSION AND ASSIGNMENT:** By placing my initials in the space(s) provided, I voluntarily give my permission to receive (initials) \_\_\_\_\_ influenza vaccine. I understand that payment for this service may be made in accordance with the provisions of Title XVIII of the Social Security Act (Medicare) and/or Title XIX of the Social Security Act (Medicaid); and/or private insurance of other third-party payor. I hereby authorize the provider of service to release information necessary for the processing of any claim for payment made on my behalf, and I authorize payment to the provider for such claim. We will file your insurance and you will be responsible for any co-pays, deductibles or non-covered charges.

\_\_\_\_\_

**Patient Signature**

\_\_\_\_\_

**Date**

**For Provider Use Only:**

Cure MD Acct: \_\_\_\_\_

Influenza Vaccine Mfgr/Lot # \_\_\_\_\_

Injection Site: \_\_\_\_\_ Right \_\_\_\_\_ Left Deltoid

Administered by: \_\_\_\_\_

Date: \_\_\_\_\_

Mfgr/Lot # Label

Clerical Demo/Ins _____ (Init) Date _____	Nurses CureMD Note _____ (Init) Date _____	Nurses/Clerical NCIR _____ (Init) Date _____	Billers Billed _____ (Init) Date _____ Paid _____
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