

Physicians Care H1N1 'Swine Flu' Vaccination Record

Patient Information

Date: _____ Time In: _____

Patient Name: _____

DOB _____ Age _____ (___M) (___F) Phone # _____

Full Address _____

The injection is free, but there is a standard \$18.00 fee for administration of medication which will be collected today. Some insurances may cover this fee, in which case you will be reimbursed; please check with your insurance company for more information.

Will you be filing insurance today?

_____ No.

_____ Yes. Please complete the following section:

Insurance Information: (Only Needed if Filing Insurance)

Primary Insurance: _____

Policy Holder _____ DOB _____

SS# _____ Relationship to Patient: _____

Secondary Insurance: _____

Policy Holder: _____ DOB _____

SS# _____ Relationship to Patient: _____

Financial Responsibility Agreement

- I will be responsible for payment of any unpaid balance that my insurance does not pay upon receipt of statement from Physicians Care. I authorize payments of medical benefits on my behalf go directly to Physicians Care.

Acknowledgement and Authorization

- I read a copy of Physicians Care "Disclosure of Protected Health Information"
- I read information about the Swine Flu Disease / Vaccines and had questions answered.
- I understand the Benefits / Risks of the vaccine and request it be given to me or my child.
- I understand I need to wait 10 minutes in lobby following injection for adverse effects.
- I have read, understand, and had any questions answered concerning the Financial Responsibility Agreement and the Acknowledgement and Authorization Section.

X _____

To be filled out by medical personnel.

H1N1 Vaccine Vaccine Lot # _____ Exp Date _____

Egg Allergy? (___N) (___Y) Flu Shot Allergy? (___Y) (___N) Recent Fever? (___Y) (___N)

Administered 0.5 ml IM in (___R) or (___L) Deltoid Staff Initials: _____

Patient: X _____

Time Out: _____

Online