209 W. 2nd Ave
Hutchinson, KS 67501
P: 620-694-2900
F: 620-694-2905

Registration Form

Name: _____ **Sex:** Male ☐ Female ☐

D.O.B. _____ **Email:** _____

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Partnered

Address: _____

County: _____ **Phone Number:** _____

Preferred Language: _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic

Race: ☐ Asian ☐ Am. Indian/Alaska Native ☐ Black/African American

☐ Native Hawaiian/Pacific Islander ☐ White

Other: _____

If under 18 years of age, please fill out all Responsible Party Information

Responsible Party: _____ **D.O. B:** _____

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Partnered

Social Security Number of Responsible Party: _____ **Sex:** Male ☐ Female ☐

If NO Insurance: (choose an option)

☐ **Self-Pay**

☐ **Sliding-Fee-Scale:**

-Number in Household _____

-Income Amount: _____

(Circle one) Annually Bi-weekly Weekly Quarterly Monthly

If Insurance: (copy of card & sub DOB or fill in)

Insurance Name: _____

Policy Subscriber: _____

Subscriber D.O.B.: _____

Policy Number: _____

Vaccine Screening Questionnaire

____ Yes ____ No Are you sick today or experiencing a high fever?

____ Yes ____ No Do you have allergies to medications, food, latex, or a vaccine component?

If so: _____

____ Yes ____ No Have you had a serious reaction to a vaccine in the past?

____ Yes ____ No Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia or other blood disorders?

____ Yes ____ No Do you have cancer, leukemia, HIV/AIDS, or any other immune system problems?

____ Yes ____ No Have you had a seizure or other nervous system problem?

____ Yes ____ No Do you have close, regular contact with someone with a weakened immune system?

____ Yes ____ No In the past 3 months, have you taken medication that weaken your immune system, such as cortisone, prednisone, other steroids, antiviral medications, anticancer drugs, or had radiation treatments?

____ Yes ____ No During the past year have you received a transfusion of blood products, or been given immune (gamma) globulin or an antiviral drug?

____ Yes ____ No For women: Are you pregnant or is there a chance you could become pregnant during the next month?

____ Yes ____ No Have you received vaccinations in the past 4 weeks?

I acknowledge that I have been offered a copy of the Reno County Health Department's Notice of Privacy Practices.

I authorize the release of the medical or billing information necessary to process claims, for insurance providers including Medicare. I have been informed that if I provide a copy of my Health Insurance or Medicare card, a claim for service will be submitted to my insurance provider. If an insurance claim is denied, services will be billed to me at full charge unless the Income Documentation section has been completed and qualifies me for a reduced rate.

I consent to the inclusion of immunization data in the Kansas Immunization Registry.

_____ _____

Client/Parent/Legal Guardian signature Date

FOR NURSE USE ONLY- IMMUNIZATIONS GIVEN: