Lake Jeanette URGENT CARE

Today's Date:__________ Patient Account #________

LAST NAME: __________________ FIRST NAME:_______________ MI:______

ADDRESS:____

CITY:________________STATE:_____ZIP CODE:__________

HOME PHONE(   )____-_____CELL PHONE(   )_____-____ EMAIL:_________________

SSN#:_____-______-________ SEX: ( )MALE ( )FEMALE AGE: ______

BIRTHDATE _____ /_____ /______ MARITAL STATUS:___________

RACE:____________ ETHNICITY:___HISPANIC_____ALL OTHER______

EMPLOYER/SCHOOL:______________________OCCUPATION:_____________

PRIMARY CARE PROVIDER (Family Doctor):______________________________

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT? Name, Address, Phone/Cell

____

PRIMARY INSURANCE INFORMATION

SUBSCRIBER'S NAME: ___________________________________

RELATIONSHIP TO PATIENT:__________________ **DATE OF BIRTH:** ___/___/___

REASON FOR VISIT:____

CURRENT MEDICATION/S:____

____

PHARMACY PREFERENCE: ____

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

NEW/EST COPAY$:______ CASH/CHECK/CHARGE SELF PAY/ UC / FP INS_____

ALLERGIES:____

WEIGHT:_______HEIGHT:______

VITALS: TEMP:_________PULSE:_______ BP:___/___ O2:_______%

LMP:___________ RESP:___________

Problem List (Today) **Past Medical History** **Surgical History** **Family History**

Check In: _______ Verification: ___________

Room time: ________

Original: 05/17/2016
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2020/2021 INFLUENZA IMMUNIZATION CONSENT

I, the undersigned, wish to receive a vaccination against influenza. I am taking the vaccine voluntarily and consent to the vaccination being given to me. I have read the information provided (Influenza VIS). I understand the risks and benefits of this vaccine. I have had an opportunity to ask questions which have been answered to my satisfaction. I hereby waive any claim for damages that I (or anyone claiming on my behalf) may have against the clinic, its directors, employees, and agents on account of any injury or misfortune I may suffer as a result of the vaccination.

THE 2020-2021 VACCINE PROVIDES PROTECTION AGAINST A/H1N1 INFLUENZA AND TWO OTHER INFLUENZA VIRUSES-INFLUENZA A/H3N2 AND INFLUENZA B.

Dated on the ____ day of _____, 20___

Printed Name: _____

Signature: _____

Date of Birth: _____ Age: _____

Please answer the following questions. A nurse or physician will review any "yes" answers.

Are you allergic to chicken, egg, or egg products?	YES	NO
Have you ever had an allergic reaction to a flu shot?	YES	NO
Are you pregnant, or think you may be?	YES	NO
Are you sick today with a fever greater than 100.4?	YES	NO
Have you been sick in the past two weeks?	YES	NO
Have you had Guillian-Barre Syndrome?	YES	NO
Are you allergic to any of the components of the vaccine? Including Thimerosal (Mercury Derivative)?	YES	NO

For Clinic/Office Use Only

0.5cc Influenza Vaccine was administered on ___/___/20__ @_____AM/PM

Site: Right Deltoid / Left Deltoid

Obstetrician Consent for vaccination, if applicable, documented _____

Name & Title of the Vaccine Administrator _____

Lot #: 283844____ Expiration Date: 06/30/2021_____