CLIENT DATA VERIFICATION

CLIENT #:

Legal Name : _____
Printed Last *Printed First* *M.I.*

Preferred First Name : _____

Interpreter Needed? ☐

Gender : ☐ Male ☐ Female **Birthdate :** _____

Race : **Ethnicity :** **Age :**

Address/City/St/Zip: _____

Home/Cell Phone: **Work Phone :**

Email Address: _____

Interested in our monthly digital newsletter: Yes ☐ No ☐

Primary Care Provider:

GUARANTOR *(If Under 18 years of age)*

Guarantor Name : _____
Printed Last *Printed First* *M.I.*

Address : **Relationship:**

City/St/Zip : **Birthdate :**

Home/Cell Phone :

Work Phone : **SSN :**

INSURANCE

Member Name: **DOB:**
Printed Last *Printed First* *Required*

Insurance Company: **SSN:**

Member Identification # : **Group # :**

Insurance Address: **City/St/Zip :**

COMMENTS I acknowledge that I have been offered the opportunity to read the Barton County Health Department's Revised Notice of Privacy (HIPAA) effective September 23, 2013. I agree that I am seeking services voluntarily without coercion and I verify that I am not required to participate in any program with the Barton County Health Department in order to receive services. I understand that the BCHD participates in the Title X program and minors may be able to authorize services independently. I am authorizing the Barton County Health Department to submit claims for reimbursement to them on my behalf and I authorize the release of records necessary to act on this request.

Signature: _____ **Date:** _____

CLERICAL ONLY:
NN:_____
Charges: _____
WebIZ:_____

BARTON COUNTY HEALTH DEPARTMENT
1300 Kansas Ave – Great Bend KS 67530
Phone:(620) 793-1902 Fax: (620)793-1903

CLINICAL ONLY:
NN:_____
Charges: _____
WebIZ:_____

VACCINE DOCUMENTATION/CONSENT FORM

I have been offered a copy of the "Vaccine Information Statement(s)" checked below. I have read, have had explained to me and understand, the information in the "Vaccine information Statement(s)". I ask that the vaccine(s) checked below be given to me or to the person named below for whom I the parent or guardian or am otherwise authorized to make this request. I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself and on behalf of the person named below.

❑ DTaP/DT/TdaP/Td ❑ HepA ❑ HepB ❑ Hib ❑ HPV ❑ Influenza ❑ Meningococcal ❑ MMR

❑ PCV13 ❑ PPV23 ❑ Polio/IPV ❑ Rotavirus ❑ Tb ppd ❑ Varicella Other _____

Signature of Patient or Parent/Guardian _____ Date _____

Client Name: _____ **Client Birth Date:** _____

PATIENT ELIGIBILITY * ** ^		
❑TITLE 19 (<19yrs) [Medicaid] ❑Uninsured (<19yrs) ❑American Indian/Alaskan Native(<19yrs) ❑Underinsured (<19yrs) [RHC/FQHC/HD only] ❑Not VFC Eligible	❑TITLE 21 (<19yrs) [SCHIP-STATE] ❑317 ❑Medicare ❑State ❑VFC Eligibility not Determined/Unknown	*Underinsured children: Insurance does not cover immunizations. Eligible through VFC program if vaccinated at a FQHC, RHC, or county health dept. **Underserved children: Are not VFC Eligible. May only be vaccinated with KIP vaccines needed for school entry at a county health dept if enrolled in federal free or reduced-price school lunch program. ^ Underserved and Underinsured children are eligible through state funded vaccine program if vaccinated at a public county health clinic.

IMMUNIZATION SCREENING QUESTIONNAIRE			
1. Is the patient to be vaccinated currently sick or experiencing a high fever?	❑Yes ❑ No	7. Has the patient, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	❑Yes ❑ No
2. Does the patient have allergies to medications, food, a vaccine component, or latex?	❑Yes ❑ No	8. Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem?	❑Yes ❑ No
3. Has the patient had a serious reaction to a vaccine in the past?	❑Yes ❑ No	9. In the past 3 months, has the patient taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	❑Yes ❑ No
4. Has the patient had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	❑Yes ❑ No	10. In the past year, has the patient received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	❑Yes ❑ No
5. If the patient to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	❑Yes ❑ No	11. Is the patient pregnant or is there a chance she could become pregnant during the next month?	❑Yes ❑ No
6. If your patient is a baby, have you ever been told he or she has had intussusceptions?	❑Yes ❑ No	12. Has the patient received vaccinations in the past 4 weeks?	❑Yes ❑ No

PROVIDER INFORMATION			
Vaccine Provider: BARTON CO HEALTH DEPT (0005)		Clinic Site: BARTON CO HEALTH DEPT (BT CHD)	
Address: 1300 E KANSAS AVE GREAT BEND 67530		Address: 1300 E KANSAS AVE GREAT BEND, KS 67530	
Phone Number: 620-793-1902	County: BARTON	Phone Number: 620-793-1902	County: BARTON