



Van Wert County General Health District-Child
1179 Westwood Dr., Ste. 300 Van Wert, OH 45891 (419)238-0808

Patient: Last Name First Name Middle Name
Street Address & PO Box Apartment #
City State Zip Sex M F
Social Security # Birth date Age
Home Phone # Cell Phone #

Primary Care Physician: Is child on WIC? YES NO

Mother/Guardian Name: Phone #
Address (if different from patient)
Email Address

Father/Guardian Name: Phone #
Address (if different from above)
Email Address

Emergency Contact: Relationship Phone #

Person Responsible for Payment:

Primary Insurance: Name on card
Birthdate Social Security #
ID # Employer Name

Secondary Insurance: Name on Card
Birthdate Social Security #
ID # Employer Name

Consent for assignment of benefits: I give consent for my insurance to be billed for services received today at the Van Wert County Health Department. I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be stated to be my responsibility by the insurance agency, as required by any contract with my insurance agency and state regulation. I also understand that my contract with my insurance agency may or may not cover some services. It is my responsibility to get information from my health insurance agency about services that are covered. If I get care outside of my health insurance plan, I am aware that I may be responsible for all charges that may be due. A returned check fee of \$25.00 will be charged to you for a check returned for insufficient funds, stopped payment or closed account.

Signature Date
Signature Date
Signature Date
Signature Date
Signature Date
Signature Date

OR: My insurance is not in-network or it is a non-covered service(s). I will self-pay for all services & fees.

Signature Date
Signature Date
Signature Date
Signature Date
Signature Date

OR: I do not have insurance coverage for my child

Signature Date
Signature Date
Signature Date
Signature Date
Signature Date

***** Please complete the back of this form*****

Patient name: _____

Date of birth: _____

This consent is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to let you know your rights to privacy with respect to your health care information.

- ❖ I give my consent to the Van Wert County Health Department (VWCHD) to use and disclose my protected health information for the purposes of treatment, payment and operations of my care and this clinic.
- ❖ I understand that my child's immunization record will be entered into the Ohio Immunization Registry (IMPACT SIIS) unless I sign a form for removal. I also understand that other entities such as but not limited to: Parent or Guardian, WIC, Physician, Other Health Departments, Dept. of Job and Family Services, School or Preschool, Head Start or Daycare, Hospital, and Ohio Department of Health might be contacted for information or records may be released when deemed necessary.

Consent for release of information for payment and operations: I authorize VWCHD to give information to the identified insurance carriers(s) for any and all payment activities.

A copy of the Privacy statement is hanging up in the waiting room and a copy can be given if asked for by the client.

Consent related to privacy Notice: I have had a chance to review the Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may get these changed notices by contacting VWCHD by phone or in writing. I understand I have the right to ask how my protected health information will be used and/or given out.

Signature for HIPAA Consent: _____ **Date:** _____

Screening Checklist for Contraindications to Vaccines for Children and Teens:

For **Parents/Guardians:** The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, ask your healthcare provider to explain it. Circle those that apply.

- | | | | |
|---|-----|----|------------|
| 1.) Is your child sick today? | Yes | No | Don't know |
| 2.) Does the child have allergies to medications, food, a vaccine component, or latex? | Yes | No | Don't know |
| 3.) Has the child had a serious reaction to a vaccine in the past? | Yes | No | Don't know |
| 4.) Has the child 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?
Has the child ever had Guillain-Barre syndrome? | Yes | No | Don't know |
| 5.) If the child to be vaccinated is between 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 | Don't know |
| 6.) If your child is a baby, have you ever been told he or she has had intussusception? | Yes | No | Don't know |
| 7.) Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems? | Yes | No | Don't know |
| 8.) Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem? | Yes | No | Don't know |
| 9.) In the past 3 months, has the child taken medications that weaken their immune system, Such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? | Yes | No | Don't know |
| 10.) In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? | Yes | No | Don't know |
| 11.) Is the child/teen pregnant or is there a chance she could become pregnant during the next month? | Yes | No | Don't know |
| 12.) Has the child received vaccinations in the past 4 weeks? | Yes | No | Don't know |

Form completed by:	Date:	Form Reviewed by:	Date:
Future Visits Reviewed and Initialed by Parent/Guardian:			
Initial____&date_____	Initial____&date_____	Initial____&date_____	Initial____&date_____
Future Visits Reviewed and Initialed by Nurse:			
Initial____&date_____	Initial____&date_____	Initial____&date_____	Initial____&date_____