Please Print

****Please fill in all lines - Put N/A if not applicable****

Madelia Community Hospital & Clinic

Date: _____ Time:_____

Patient Name: _____ Birthdate: _____

LAST FIRST MIDDLE

Patient Info:

Address: _____

City, State, ZIP _____

Phone #: _____

Soc Sec #: _____

Employer: _____

Employer Phone #: _____

Sex: _____ Marital Satus: _____

Race: _____ Religion: _____

Advanced Directive: (circle one) Yes / No

Primary Doctor: _____

Email: _____

Emergency Contact #1

Name: _____

Address: _____

City, State, Zip _____

Phone #:_____

Relationship_____

Emergency Contact #2

Name: _____

Address: _____

City, State, Zip _____

Phone #:_____

Relationship:_____

Person Responsible for Bills (Guarantor)

Name: _____

Address: _____

City, State, Zip _____

Phone #:_____

Soc Sec #: _____

Birthdate: _____

Relationship_____

Insurance Info

Primary Ins

Subscriber Name: _____

Subsriber ID#: _____

Group #: _____

Secondary Ins

Subscriber Name: _____

Subsriber ID#: _____

Group #: _____

Work Comp

Accident Date: _____

Accident Type: (circle one) Employer / Auto

- If Auto Accident, Auto Insurance & phone # here

_____

_____

- If Work related, Employer name & phone # here

_____

_____

Madelia Community Hospital & Clinic

Influenza Vaccination

Name: _____

DOB: _____

Billing Preference (Please check one)

___ I wish to receive my flu vaccine through the "Direct Access" program. I do not wish to have my insurance billed for the flu vaccine. (Medicare Patients not eligible) I will pay the cost of:

$57 /$77 for High Dose Vaccine (Recommended for patients 65 & older)

Method of Payment: □ **Cash** □ **Check** □ **Credit Card**

___ Please bill my insurance company for the cost of my flu vaccine and the administration fee.

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.	YES	NO	Don't Know
1. Is the person to be vaccinated sick today? Fever of 100.5 or higher.			
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?			
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?			
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?			

Form completed by: _____Date:_____Time_____

Nurse reviewed by: _____ Date:_____Time_____

Site: Left Deltoid

Right Deltoid

Left Thigh Other:

Right Thigh

Place vaccine label here:

MNVFC (18 yrs and younger) YES NO

Provider visit at time of vaccine: YES NO

Entered in Allscripts or MIIC_____

Billing codes:

Admin—**G0008-Medicare**

Admin—**90471-Other**

Dx—**Z23**

Nurse signature:_____ Date:_____Time_____