Franciscan Healthcare

BRING A COPY OF YOUR CURRENT INSURANCE CARD

INSURANCE CARD
____Photo
____Copy

PATIENT ***(use legal name)***
Name *(last)*_____ *(first)*_____
Date of Birth_____Age___ Sex ___ Social Security #_____
Marital Status:____Spouse's Name_____Spouse's Date of Birth_____
Race _____ Language: English Spanish Other _____
Address *(Physical, PO Box)*_____
(City, State, Zip Code) _____
Telephone *(Home)* _____ *(Cell)* _____
Email Address_____

PATIENT EMPLOYMENT *(circle)* Full-time Part-time Self-employed
Employer/Business Name _____
Address *(Physical, PO Box)*_____
(City, State, Zip Code) _____
Telephone *(Main)*_____ Contact Name *(if WC)* _____

GUARANTOR ***(use legal name)*** Guarantor Relationship to Patient _____
Name *(last)*_____ *(first)*_____
Date of Birth_____ Sex_____ Social Security #_____
Address *(Physical, PO Box)*_____
(City, State, Zip Code) _____
Telephone *(Home)* _____ *(Cell)* _____

INSURER'S EMPLOYMENT INFO *(circle)* Full-time Part-time Self-employed
Policyholder_____
Employer/Business Name _____
Address *(Physical, PO Box)*_____
(City, State, Zip Code) _____
Telephone *(Main)*_____

Franciscan Healthcare

INFLUENZA VACCINATION
ASSESSMENT AND CONSENT FORM

Patient's Name:_____ Birth Date:_____

Doctor:_____

Have you received an influenza vaccination in the past 30 days? Yes_____ No_____

(If yes, vaccination is not indicated. If No, continue assessment for contraindications.)

Have you ever had a severe (anaphylactic) reaction to a flu shot? Yes_____ No_____

Are you allergic to eggs or egg products, thimerosal-containing products (eye contact lens solution) or mercury containing products? Yes_____ No_____

Do you currently have an illness with fever? Yes_____ No_____

Consent for Influenza injection:

The information on the flu vaccine statement was available to me. I have had a chance to ask questions and these have been answered to my satisfaction. I understand the benefits and risks of the vaccine and asked that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I accept responsibility for seeking medical attention for any problems with this vaccination. Franciscan Healthcare will bill your insurance carrier. I authorize direct payment of benefits to Franciscan Healthcare. I will be responsible for the entire unreimbursed balance of the claim to the extent permitted by law.

Signature of Patient/Parent/Guardian: _____ Date:_____

FOR NURSE USE ONLY:

Influenza Administered

Influenza Vaccine
Site: RD/LD
RVL/LVL

Administered By:_____

Date Given:_____

Manufacturer:

09/14/20 hlk

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