Immunization Clinic

Registration and Consent Form

PLEASE PRINT CLEARLY

Patient's First Name: ______________________________ Middle Initial: ________

Patient's Last Name: ______________________________

Date of Birth: ______________________ Primary Phone Number: ______________________

Demographic Information (please circle)

Race: White/Caucasian Black/African American Native Hawaiian Alaska Native Asian American Indian Other

Ethnicity: Hispanic/Latino NOT Hispanic/Latino Other Preferred Language: ______________________

Sex: Male Female Transgender

IF NO INSURANCE, PLEASE COMPLETE THE FOLLOWING TO REQUEST DISCOUNTED SERVICES

"I state that there are ________ number of people living in my household and
the combined household income is $ ______________ per week/month/year" (circle one)

Parent/Legal Guardian Information

Parent/Legal Guardian Name: ______________________________

Parent/Guardian Date of Birth: ________________ Relationship to Patient: ______________________

Phone Number: ______________________

I have read the Morrow County Health District's [MCHD] Patient Financial Policy and agree to the terms of this policy. I understand that I may request a copy to take home if desired. I also understand that it is my responsibility to verify with my insurance company coverage of all services requested, and that I will be responsible for any balance not paid or covered by my insurance company. I agree to pay any amount remaining due to the Morrow County Health District for the service(s) provided.

I understand that vaccine information will be entered into the state-wide Immunization Registry for the purpose of immunization tracking, recall and recording, unless I request otherwise. I request and authorize MCHD and its personnel to deliver medical care requested. I attest that the above information is true and correct to the best of my knowledge and that I am authorized to request medical care for the above named person. I have received the MCHD Notice of Privacy Practices regarding the uses and disclosures of the health information for me and/or my child.

Patient OR
Parent/Guardian Signature: ______________________________ Date: ________________