Fairfield County Health Department

Immunization Clinic

CHILDREN / TEEN PATIENT REGISTRATION
(18 years or younger)

Office use only: VFC Private Self-Pay

Patient Information

Patient Name _____ Sex _____ Date of Birth _____Age _____ Race_____

Address_____ City _____ State _____ Zip _____

Home phone #_____ Alternate phone #_____

Family Doctor _____

Responsible party for patients under 18 yrs of age:

Mother/Father/Guardian: _____DOB: _____

Address (if different): _____

Home phone #_____ Alternate phone# _____

Email:_____

Emergency Contact

I give my permission for the staff/providers of the Fairfield County Health Department to discuss any of my medical or financial information with only those I have listed below or my legal guardian (attorney in fact if applicable).

Name (Print) _____ Relationship _____ Phone #_____

Name (Print) _____ Relationship _____ Phone #_____

**May we leave a message on your home phone & cell phone or alternate phone? Yes _____ No _____

Consent for Additional Party to bring child in absence of parent. (*Optional*)

I (Parent/Guardian Name) _____ am authorizing (Authorizing Party) _____

to bring my child (Child's Name) _____ to any upcoming appointments he/she may have.

Parent/Guardian Signature _____ Date _____

****Please be advised that this statement will not change unless you submit in writing requesting the person you authorized to be removed. Only valid for one year from date signed.**

Immunization Record Release Authorization:

I authorize the Fairfield County Health Department to release Immunization Records via mail, fax, or email to *(check all that apply)*:

☐ Physicians ☐ Schools/Preschools ☐ Daycare Facilities ☐ Other _____
(e.g. Employer)

_____ _____
Signature of Patient or Responsible Party Date

Primary Insurance:	**Secondary Insurance:** ***(If Applicable)***
Insured Name:	Insured Name:
Birthdate:	Birthdate:
Relationship to Patient:	Relationship to Patient:

Please provide your Insurance card to be copied and placed in your file..
I authorize the Fairfield County Health Department to release pertinent information to my insurance company when requested, or to facilitate payment of a claim. I authorize the Fairfield County Health Department to apply for benefits on my behalf for covered services rendered by the patient and for payment to be made payable to the Fairfield County Health Department. I agree to bring the most current copy of my insurance card with me to each visit and will pay all applicable co-pays or deductibles on the same day I receive medical services. I agree with the consent and the provisions of medical treatment and the financial policy. I understand that the services provided may or may not meet the criteria for coverage under Medicare, Medicaid, and/or other insurance carriers. My signature indicates that I agree to pay all charges/unpaid deductibles regarding this service(s) if Medicare, Medicaid, and/or other private insurance carriers fail to cover the charges.

_____ _____
Signature of patient or Responsible party Date

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have reviewed a copy of the Notice of Privacy Practices provided to me by the Fairfield County Health Department. I understand that this Notice explains what the Fairfield County Health Department does to protect the use or disclosure of my health care information. I will share this Notice with other adult members of my household. I understand that I may request a copy of this Notice to be given to me and will refer to it if I have questions. I also understand that I should call the Health Department at (740) 652-2800 if I have questions or concerns about my privacy rights.
Would you like a copy of the Privacy Practices? Yes or No

VFC Eligibility Determination-Office use only

	Yes	No
1. Receive Medicaid	□	□
2. Uninsured	□	□
3. American Indian / Alaska Native	□	□
4. Underinsured – defined below*	□	□

***The "Underinsured" category is very narrowly defined for children eligible for VFC vaccine in Local Health Departments and Federally Qualified Health Centers. Patients with high deductible or high co-payment costs are never considered "Underinsured."**

Form Reviewed By:

_____
(Front Desk Personnel)

For Office Use Only
VFC Eligibility Yes □ No □ Nurse / Clerk Initials _____