MaineHealth
CARE AT HOME

# MHCAH Flu Clinic – Patient Registration

## PATIENT INFORMATION

| FIRST NAME | LAST NAME | GENDER | |
|---|---|---|---|
| | | ☐ FEMALE ☐ MALE | |
| **DATE OF BIRTH (MM/DD/CCYY)** | **SOCIAL SECURITY NUMBER** | **PHONE NUMBER W/ AREA CODE** | |
| | | | |
| **STREET ADDRESS** | **TOWN/CITY** | **STATE** | **ZIP CODE** |
| | | | |
| **INTERPRETER REQUIRED?** | **PREFERRED LANGUAGE?** | **YOUR PRIMARY DOCTOR / PCP?** | |
| ☐ NO ☐ YES | | | |
| **EMERGENCY CONTACT:** | | | |

## PATIENT/SUBSCRIBER INSURANCE

| | PRIMARY INSURANCE | SECONDARY INSURANCE |
|---|---|---|
| **Name of Insurance** | | |
| **Relationship to Subscriber** | | |
| **Insurance ID #** | | |
| **Effective Date** | | |

| **Screening questions:** | NO | YES |
|---|---|---|
| 1. Have you ever had a flu shot or flu-mist? (If not, we recommended that you stay in the area for about 15 minutes after receiving the vaccine). | ☐ | ☐ |
| 2. Have you had a severe reaction to a previous influenza vaccine? | ☐ | ☐ |
| 3. Are you allergic to eggs or chicken? | ☐ | ☐ |
| 4. Do you have a past history of Guillian-Barre Syndrome? | ☐ | ☐ |
| 5. Do you have a chronic disease? | ☐ | ☐ |
| 6. Are you sick with a fever? | ☐ | ☐ |

***Note:** If the "Flu-mist" option is chosen or recommended, there will be other screening questions that your nurse will discuss with you.

I have been provided a copy of **the "Inactivated" injection or the "Live" intranasal Influenza Vaccine Sheet** and had the opportunity to ask questions. I understand the benefits and risks of the influenza vaccine as described. I request that the vaccine be given to me or to the person named for whom I am authorized to sign. I acknowledge that no guarantees have been made concerning the results of the vaccine. I hold harmless, MaineHealth Care at Home, its employees, and the facility in which the vaccine was received. I request that payment of authorized benefits be made on my behalf directly to MaineHealth Care at Home. I AGREE TO PAY THE AMOUNT(S) NOT PAID OR IF MY CHARGES ARE DENIED FOR ANY REASON. I hereby acknowledge my understanding of MaineHealth Care at Home's Notice of privacy practices.

_____ _____ _____

**Patient/Guardian or Auth Representative** **Reason patient is unable to sign** **Date**


**<u>Injection documentation below to be completed by nurse</u>:**

**Dose 0.5 ml 0.25 ml Deltoid / VL injection site L / R (please circle) or Flu-mist**

**Vaccine:**_____ **Expires:** _____ **Lot #**_____

**Time of admin** _____ **am/pm** **Comment: (if needed)** _____

**Nurse's signature:**_____ **Date:**_____