

2014 - 2015 Insurance Information Form

Town of Sharon Health Department

The completion of this form is necessary for every vaccine recipient. If no insurance information is available, please fill out as much as possible using existing information.

Information about the person to receive vaccine (please print): *Required Fields

Name: (Last, First, MI)*	Date of birth: *	Age*	Sex: (Circle)*
	_____ Month Day Year		Male Female
Street Address:*			
City:*	State: *	Zip:*	Phone:*
			()

Insurance Information: Include the whole member ID number and any letters that are part of that number

Name of Insurance Company:*	Member ID Number:*	Group ID Number: (if available)
MEDICARE #	Is Medicare Primary?	Is Subscriber Employed?
	YES NO	YES NO

If person getting vaccinated is not the subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)*	Subscriber's Date of Birth: *	Sex: (Circle)*
	_____ Month Day Year	Male Female
Subscriber's Street Address: * (If different from address above)		
City:*	State:*	Zip: *
		()
Patient Relationship to Subscriber: (Circle)* Spouse Child Other		

I give permission for my insurance company to be billed.

X _____ Date: _____
 (Signature of patient, parent or legal guardian)

For Clinic/Office Use Only:

Vax Type	Vax Manufacturer	Dose	Preserv Free	Injection Route	Injection Site (Circle)	VIS 8/19/14 given
IIV3	Sanofi	.5ml	No	IM	R Arm L Arm	
IIV4	GSK				R Leg L Leg	
LAIV4	Medimmune		NA	Intranasal		

For children 18 years of age and younger:

<input type="checkbox"/> Is enrolled in Medicaid (includes MassHealth and HMOs, etc., if enrolled through Medicaid) <input type="checkbox"/> Does not have health insurance <input type="checkbox"/> Is American Indian (Native American) or Alaska Native <input type="checkbox"/> Has health insurance and is not American Indian (Native American) or Alaska Native

Provider Name: **Sharon Health Department**
 Provider Address: 90 South Main Street, Sharon, MA 02067

MDPH Provider PIN# 11537

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Town of Sharon - Department of Health

Complete this side only if receiving the Flu Mist and under 18 years old

The following questions will help us to know if you (or your child) can receive the 2013 Seasonal Flu Vaccine. Please mark YES or NO for each question.

A. If you answer “YES” to one of more of the four questions, you (or your child) will not be able to receive the flu vaccine. If you answer “NO” to the following questions you (or your child) will receive the vaccine unless a concern arises following additional screening. If you are not sure of the answers to these questions, please check with your healthcare provider.

Information about the person to receive vaccine	YES	NO
1. Do you have a serious allergy to eggs, egg proteins or arginine?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have a serious allergy to gentamicin, neomycin, polymixin or gelatin?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>

B. There are two kinds of flu vaccine. Your answers to the following questions will help us determine which vaccine you may receive.

Information about the person to receive vaccine	YES	NO
1. Have you received a flu vaccination before?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had a life-threatening reaction to a flu vaccination before?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver nerves, or blood?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a weak immune system (for example, from HIV, cancer or medications such as steroids or chemotherapy) that lowers the body’s resistance to infection?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you a long-term aspirin or aspirin-containing therapy (for example, do you take aspirin every day)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you pregnant or nursing?	<input type="checkbox"/>	<input type="checkbox"/>
8. Please let us know if you have close contact with anyone who has a weakened immune system (for example, an individual who has had a bone marrow transplant and is in a negative pressure hospital room). Please describe:	<input type="checkbox"/>	<input type="checkbox"/>

Please be sure to complete all of the information on the front side of this form

Thank you.