PANCARE OF FLORIDA, INC.

INFLUENZA VACCINE INTAKE FORM

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial**

Social Security Number | **Date of Birth** | **U.S. Military Service (☑ one):** ☐ None ☐ Currently Serving ☐ Discharged

Address | **City** | **State** | **Zip Code** | **County**

Home Phone ( )	**Work Phone** ( )	**Cell Phone** ( )	**Email**

Marital Status (☑ one): ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Primary Language Spoken: ☐ Limited English

Patient's Relationship to Responsible Party (☑ one): ☐ Self ☐ Spouse ☐ Natural Child ☐ Parent ☐ Foster Child

Gender (☑ one): ☐ Female ☐ Male ☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female ☐ Other ☐ Choose Not To Disclose

Sexual Orientation (☑ one): ☐ Choose Not To Disclose ☐ Lesbian or Gay ☐ Straight (not lesbian or gay) ☐ Bisexual ☐ Something Else ☐ Don't Know

Race (☑ one): ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ More Than One Race ☐ Choose Not To Disclose

Ethnicity (☑ one): ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Choose Not To Disclose

Are you a migrant/seasonal worker or a family member of a migrant/seasonal worker? ☐ Yes ☐ No

What is your annual income? ☐ $0-$12,490 ☐ $12,491-$15,614 ☐ $15,615-$18,735 ☐ $18,736-$21,858 ☐ $21,859-$24,980 ☐ $24,981 & UP

Number of people in household:_____

Emergency Contact	**Phone** ( )	**Relationship to Patient**

RESPONSIBLE PARTY INFORMATION (enter name of person *FINANCIALLY* responsible for your account)

Last Name | **First Name** | **Middle Initial**

Mailing Address | **City** | **State** | **Zip Code** | **County**

Home Phone ( )	**Work Phone** ( )	**Cell Phone** ( )	**Date of Birth**	**Social Security Number**

INSURANCE COMPANY – *INCLUDING MEDICAID*

Primary Insurance | **ID#** | **Group #** | **Insurance Company Address**

Name of Insured | **Date of Birth** | **Insured's Employer**

Relationship to Responsible Party: ☐ Self ☐ Spouse ☐ Natural Child ☐ Step Child Parent ☐ Foster Child ☐ Foster Parent

Secondary Insurance | **ID#** | **Group #** | **Insurance Company Address**

Name of Insured | **Date of Birth** | **Insured's Employer**

Relationship to Responsible Party: ☐ Self ☐ Spouse ☐ Natural Child ☐ Step Child Parent ☐ Foster Child ☐ Foster Parent

Assignment and Release: *I authorize my insurance benefits to be paid directly to PanCare Health. I also authorize PanCare Health to release any information required to process this claim.*

SIGNATURE:_____ **DATE:**_____

Please complete the information below if you would like to receive the flu vaccine from PanCare of Florida, Inc.

Please answer the following questions:	Yes	No	Unknown
1. Do you feel sick today?			
2. Have you ever had a serious allergic reaction to eggs? If yes, as a precaution, it is recommended you do not receive the flu vaccine until you have consulted your private healthcare provider.			
3. Have you ever had a serious reaction to a previous dose of flu vaccine?			
4. Have you ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?			
5. Are you allergic to latex?			
6. Are you pregnant or nursing? If so, please consult your private healthcare provider.			
7. Do you have a bleeding disorder (hemophilia or thrombocytopenia) or are you on anticoagulant therapy?			
8. Are you allergic to thimerosal (a preservative) other than contact lens sensitivity?			
9. Have you ever received a flu shot before?			

Consent and Release Statement

I have read or have had explained to me the above information and received a copy of the Vaccine Information Statement(s) for the Influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe that I understand the benefits and risks of the Influenza vaccine and request that the vaccine be given to me.

Signature of patient:_____ Date:_____

Manufacturer:_____ Lot #:_____ Expires:_____

Site: □ L Deltoid □ R Deltoid Dose:_____ ml

Signature:_____ Date:_____