LASSEN COUNTY

Health and Social Services Department
Department of Public Health
1445 Paul Bunyan Rd, Suite B
Susanville, CA 96130
530-251-8183

Patient Registration Form

Last Name:______________________________ First Name:______________________________

Date of Birth: ______________ Age:________ Mother's **First** Name:__________________________

Physical Street Address:____

____

City: ______________________________ State:__________ Zip Code: ___________________

Mailing Address (if different than above) ____

____

Cell Phone Number:_____________________ Message Phone: ______________________________

What services are you requesting today?____

____

Are services for employment purposes? ____Yes ____No If yes, will they be billed? ____Yes ____No

Place of Employment:____

Insurance Information: ____Medi-Cal ____PACT ____CMSP ____Private ____Other:______________

Social Security Number for Medi-Cal Patients: ______________________________________

Marital Status: ____Married ____Single ____Separated ____Divorced ____Other

Race: ____ American Indian or Alaska Native ____Asian ____Black or African American

____Native Hawaiian or Pacific Islander ____White ____Two or more Races ____Other Race

Ethnicity: Are you Hispanic? ____Yes ____No

I consent to the following from Lassen County Public Health to the information listed above:

____ Text Messages ____ Phone Calls/Voicemails ____Mail

Signature____ **Date**_____/______/_______

Relationship if not signed by patient: ____

FOR OFFICE USE ONLY

Fee Paid:_________ **Fee Waived:**__________ **Sent for Employer Billing:** _____________

CAIR #__________ **VIS Given:**____________

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ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, ____ have received a copy of this office's

Notice of Privacy Practices.   Effective January 1, 2019.

Print Name:____

Signature:____

Date: ____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices Acknowledgement

Could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) ____

Type of Vaccine	Site	Lot #	Exp. Date	Vaccinator

LASSEN COUNTY IMMUNIZATION CLINIC

Section 1: Information about Person Receive Vaccine (Please Print)

NAME (Last)		(First)		(M.I)	**DATE OF BIRTH** Month_______ Day_____ Year_______	
ADDRESS					**AGE**	**GENDER** M / F
CITY	**STATE**		**ZIP**		**PHONE NUMBER**	
ALLERGIES:						

IMMUNIZATION CLINIC SCREENING QUESTIONS

Please answer "YES" or "NO" to each question by placing a check mark in the appropriate space. After completion, please return to Receptionist along with any previous immunization records (shot records).

IS THE PERSON TO BE IMMUNIZED… **YES** **NO**

1. Sick or does he/she have a high fever? _____ _____
2. Have anyone at home taking cortisone, prednisone, or cancer treatments? _____ _____
3. Have anyone at home who has cancer, leukemia, AIDS, or some other immune system problem? _____ _____
4. Ever had a reaction to a vaccine which was so bad that you took him/her to the doctor or hospital? _____ _____
5. Any of his/her sisters or brothers or parents, ever had a convulsion or seizure? _____ _____
6. Have any other problems or illnesses affecting his/her brain or nerves? _____ _____
7. Have an **allergy** to any of the following things: **Gelatin,** medicines called **neomycin,** or **streptomycin, yeast,** or something in vaccines called **Thimerosal**, or **latex**. _____ _____
   What happens?
   ____
8. Had a blood transfusion or a gamma globulin shot in the last 12 months? _____ _____
9. Women of childbearing age – could you be pregnant? _____ _____

WHAT SERVICES/IMMUNIZATIONS ARE YOU REQUESTING TODAY?

____

Mother's first name ____

Signature: ________________________________ **Date:** ________________
Parent signature is required if under 18 years of age
(except for Pregnancy Test)

Fee: ______________Fee waived: ______________IZ's Administered______________________________

HIPAA Privacy Statement

Definition of **Protected Health Information (PHI)**

Any individually identifiable health information, whether oral or recorded in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual. Any data transmitted or maintained in any other form or medium by covered entities, **including paper records, fax documents and all oral communications,** or any form, i.e., screen prints of eligibility information, printed emails that have identified individual's health information, claim, or billing information, hard copy birth or death certificate. **Protected health information excludes:** school records that are subject to the Family Educational Rights and Privacy Act; and employment records held in the County's role as an employer.

Uses and disclosures for Public Health Activities

According to the Health and Safety Code Part II 45 CFR 164,501, Lassen County Public Health Department is a covered entity which may disclose protected health information for certain specified public health activities which may be but not be limited to:

- Disease prevention and control, including reporting
- Vital records reporting
- Public Health surveillance
- Legally authorized disclosure of protected health information to a person or persons who may be at risk of contracting or spreading a reportable disease
- Certain providers hired by employers may provide information to the employer related to workplace medical surveillance or work-related illness or injury
- Reporting under Food and Drug Administration requirements for adverse events or problems related to certain regulated projects.

FORM LOCATED: " S:\PHE\Forms\Immunization "