TMC
TRUMAN MEDICAL CENTERS
Better. For Everyone.

JACOHD PATIENT INFORMATION FORM

I. PATIENT INFORMATION

CLINIC:_____

Name of Person being seen:_____
Last First MI

Also Known As _____ Date of Birth: ___/___/___ Age: _____

Ethnicity: ☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander ☐ Black/African American ☐ Hispanic ☐ White

Other_____ Nationality: _____ Social Security Number: _____-_____-_____

Address: _____
Street City State Zip

Home /Cell Phone: (____)_____ Gender: M ☐ F ☐

Responsible Party (if other than client)

Name: _____ Date of Birth___/___/_____ Gender: M ☐ F ☐

Social Security Number _____-_____-_____ Marital Status _____ Relationship to Client _____

Address (if different from client) _____ Phone: _____
City State Zip

II PAYMENT AND INSURANCE INFORMATION

Please check the appropriate box. If you check one of the following statements go directly to the next page for screening questions

☐ ***I currently do not have insurance*** ☐ ***My insurance does not cover vaccine***

☐ ***I currently have Medicaid #_____***

Insurance Information:

Primary Insurance: _____ Circle one: PPO, HMO, ACCESS Other:_____

Policy Number: _____ Group Number: _____

Relationship to Insured: Self ☐ Spouse ☐ Dependent ☐

Name of Insured: _____ Insured's Date of Birth: _____/_____/_____
Last First MI

Insured's Social Security Number: _____-_____-_____ Gender: M ☐ F ☐

III AUTHORIZATION AND CONSENT

Personal Financial Responsibility: By signing this form and in return for the services rendered by JACOHD, TMC and the Physicians, I am personally responsible for all TMC fees and physician fees not paid by any third party on my behalf.

Assignment of Insurance Benefits: I hereby assign all my interest and rights to all insurance benefits, otherwise payable to me from any policy of insurance issued in my name or on my behalf, to JACOHD, TMC, TMC physicians and/or University Physician Associates. I agree that TMC and/or physicians may disclose any portion of my medical, financial or personal information to any person or organization requiring such information as a condition of paying, receiving payment for or justifying payment for my health care or the health care of one for whom I am responsible. I further authorize payment of all insurance benefits, otherwise payable to me, for all treatment provided directly to Jackson County Health, Truman Medical Centers, Inc. and/or University Physician Associates.

My signature indicates that I have reviewed a copy of the Notice of Privacy Policy and have read, or had read to me the Vaccine Information Statement (VIS) for each vaccine that I am requesting be given to the person named on the form. Current VIS given and screened per protocol _____ Nurse's Initials

Signature of Patient or Legal Guardian _____
Sign

_____ _____
Print **Date**

Form# 90245, Date: 01/17, MEC Rev

Immunization Screening Questionnaire

Please answer questions about the person receiving the vaccine(s) by circling yes or no

1. Are you sick today? Yes / No
2. Do you have a fever? Yes / No
3. Do you have a food, medication or vaccine allergy? Are you allergic to yeast? Yes / No
4. Have you ever had a severe reaction to a vaccine, medication or wasp sting? Have you developed an allergic reaction (hives) or wheezing following any of these? Yes / No
5. Have you ever had a seizure or convulsion? Yes / No
6. Do you have or live with or take care of someone with Cancer, AIDS or an immune disorder or are you being treated with cancer medications, radiation or receiving steroid therapy lasting 2 weeks or longer? Yes / No
7. Do you take cortisone, prednisone, other steroids or anticancer drugs or have you had any x-ray treatments? Yes / No
8. During the past year, have you received a blood transfusion or blood products, or have been given a medicine called immune (gamma) globulin? Yes / No
9. Have you had an allergic reaction to latex, eggs, gelatin or neomycin? (circle) Yes / No
10. Have you ever had a life threatening reaction to mouse protein or thimerosal? Yes / No
11. Have you had your thymus removed, had myasthenia gravis, Di George syndrome, or thymoma? Yes / No
12. Do you have severe renal impairment? Yes / No
13. Have you received any vaccinations in the past 4 weeks Yes / No
14. Did you bring your vaccination record card with you today? Yes / No

    It is important for you to have a personal record of your vaccinations. If you don't have a record card, ask your health care provider to give you one. Bring this record with you every time you seek medical care. Keep this card in your wallet or purse, and make sure your health care provider records all your vaccinations on it.

Additional Questions for Females Only:

15. Are you nursing, pregnant or is there a chance you could become pregnant during the next month? Yes / No

    Yes – How many weeks _____ / No
16. Are you currently using a birth control method? Yes / No
17. What is the first day of your last menstrual period? _____

----------FOR CLINIC NURSE USE ONLY----------

Temperature if applicable_____

Payment Source: VFC 317 Payable

VIS Given	Vaccine	Date	Mfg	Lot #	Exp	Amount	Site

Form# 90245, Date: 01/17, MEC Rev