Site: _____

1. Last Name_____ First Name_____ MI___

2. Date of Birth_____

3. Race: ☐ White ☐ Black ☐ Am. Ind. /Alaskan Native ☐ Asian/Pacific Islander

4. Sex: ☐ Male ☐ Female Ethnicity: Hispanic Origin? ☐ Yes ☐ No

Mother's Full Maiden Name _____

PLEASE COMPLETE MAILING INFORMATION IF DIFFERENT ON ID

5. Address_____

6. Telephone Number_____ (during the day)

High Dose Flu Vaccine

65 Years and Older

☐Medicare
☐Aetna Medicare
☐BCBS Medicare
☐UHC Medicare
☐Humana
☐Medicaid
☐UHC
☐No Ins

☐Aetna
☐BCBS
☐Cigna
☐Health Choice
☐Tricare (need policyholder ssn#)
_____

For Health Dept Use Only
Amount Paid $_____
☐NO INS CARD

For adult patients 65 or over to be vaccinated: The following questions will help us determine if there is any reason we should not give you injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Are you 65 or over?	☐	☐	☐
2. Are you sick today?	☐	☐	☐
3. Do you have any allergies? If so, please list:	☐	☐	☐
4. Do you have an allergy to eggs or to a component of the vaccine?	☐	☐	☐
5. Have you ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐

STATEMENT OF PERMISSION AND ASSIGNMENT: By placing my initials in the space(s) provided, I voluntarily give my permission to receive (initials) _____ influenza vaccine. I understand that payment for this service may be made in accordance with the provisions of Title XVIII of the Social Security Act (Medicare) and/or Title XIX of the Social Security Act (Medicaid); and/or private insurance of other third-party payor. I hereby authorize the provider of service to release information necessary for the processing of any claim for payment made on my behalf, and I authorize payment to the provider for such claim. We will file your insurance and you will be responsible for any co-pays, deductibles or non-covered charges.

_____ _____

Patient Signature **Date**

For Provider Use Only:

Cure MD Acct: _____
Influenza Vaccine Mfgr/Lot # _____
Injection Site: _____Right _____ Left Deltoid
Administered by: _____
Date: _____

Mfgr/Lot # Label

Clerical	Nurses	Nurses/Clerical	Biller
Demo/Ins_____ (Init)	CureMD Note _____ (Init)	NCIR _____ (Init)	Billed _____(Init)
Date _____	Date _____	Date _____	Date _____
			Paid _____