Bear River Health Department
85 E 1800 N, North Logan, Utah 84341
Tel.: (435) 792-6570 Fax: (435) 752-1570

Patient Information Sheet

Patient Information:

Patient Name:			
Patient Birthday:		Patient Age:	
Patient Sex:	☐ Male ☐ Female	Email:	
Patient Race:	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Hispanic ☐ Other		
Patient Address:		City:	
State		Zip code:	
Phone Number			
I understand that Bear River Health Department may contact me by text or phone call to remind me of any scheduled appointment			
Text Number:		☐ Please DO NOT send me reminders by voice or text	
If Patient is under 18 provide the following:			
Patient's Parent/Legal Guardian Name:			
Patient's Parent/Legal Guardian Date of Birth:			
Relationship to Patient:			

Insurance Information:

Insurance Company:			
Policy Holder Name:		Policy Holder Birthdate:	
Policy or Subscriber ID#	☐ Male ☐ Female	Email:	
Policy Holder Address:		City:	
State		Zip code:	
Policy Holder relation to Patient:			
Policy Holder Phone Number:			
Relationship to Patient:			
My current insurance status is:	☐ Uninsured. I/my child do/does not have health insurance ☐ Insured. I/my child do/does have health insurance, and it covers all or part of the cost of immunizations.		

Signature of Client (or Parent/Guardian/ Representative)		**Date:**	

HIPAA

I acknowledge receipt of a copy of the Bear River Health Department (Health Department) Notice of Privacy Practices- For Protected Health Information (Notice) which I have or will carefully review, and acknowledge my rights for a more complete description and understanding of potential uses, disclosures of and/or requests for such Protected Health Information by the Health Department

I acknowledge that the Health Department reserves for itself the right to change the terms of its Notice at any time, and that if the Health Department does not change the terms of its Notice, I acknowledge the right to obtain a copy of the current revised Notice at any Health Department office.

Signature of Client (or Parent/Guardian/ Representative)		**Date:**	

Consent for Services:

I have been provided with information about the vaccine I am receiving today. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine.

Signature of Client (or Parent/Guardian/ Representative)		**Date:**	

Are you allergic to eggs?	☐ Yes ☐ No

Office Use Only

Payment Method: (Circle one)	☐ Cash ☐ Check ☐ Charge	Amount Collected:	
Employer Billing:			
Flu Lot:		Site:	
Pneu Lot:		Site:	
Nurses Initials:		Site:	