NON-ESTABLISHED PATIENT
FLU SHOT ONLY

tcc | The Children's Clinic
WELCOMING FAMILIES SINCE 1911

Patient Registration and Consent - Influenza Vaccine

The Children's Clinic is happy to be able to offer flu shots to the immediate family of our patients this year! We hope that you find this a convenient option for immunizing your family against the flu. Please complete and sign one form for each family member who is not an established patient at TCC. Established patients do not need to fill out this form.

Section I: Information about your YOUNGEST child who is an established patient at TCC

(You do not need to fill out information for all children, just your youngest established patient)

First Name:	Last Name:	M.I.:	Date of Birth:

Section II: Information about Parent or Family Member to Receive Vaccine

(EACH person receiving flu shot is required to fill out this form)

First Name:	Last Name:	M.I.:	Date of Birth:
Address:		Phone Number:	
City, State, Zip:	Gender: M / F	Email address:	

Section III. Insurance - fill out OR present your insurance card

Insurance Company		Policy Holder's Name:	
Policy Holder Relationship to patient:	Group Number:	Policy Number:	Policy Holder DOB:

Section IV: Screening for Vaccine Eligibility

1. Do you have any health conditions, such as heart disease, diabetes or asthma? □ yes □ no □ don't know

   If yes, please list:

2. Do you have allergies to latex, medications, food (eggs) or vaccines? □ yes □ no □ don't know

   If yes, please list:

3. Have you ever had a reaction after receiving a vaccination, including feeling faint or dizzy? □ yes □ no □ don't know

4. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barre syndrome or other nervous system problem? □ yes □ no □ don't know

5. For women: Are you pregnant or considering becoming pregnant in the next month? □ yes □ no □ don't know

Section V: Consent

I hereby authorize The Children's Clinic, P.C. to provide medical services to the above named patient and to use and release medical information as required for treatment, payment and health care operations. I also assign The Children's Clinic all payments to which I am entitled for medical and surgical expenses. I understand that I am financially responsible for all charges whether covered by insurance or not and that balances will be added to the Guarantor account of my child(ren) or the established patient(s) at TCC. I understand insurance copays are due at the time of service. I have received a copy of the current Privacy Notice and Notice of Referral Rights & Financial Interest of The Children's Clinic.

Name of person receiving flu shot: ______________________________
(please print)

Signature: ______________________________ Date: ______________