Tri-State
Memorial Hospital &
Medical Campus

Influenza Vaccination Registration Information

Date of Service___________________________________

Patient Name___________________________________ Sex ______ Age ______ Birthdate __________________

Patient Address ______________________________ City _____________ State ______ Zip________________

Phone# (   )___________________________________ Cell Phone (   ) __________________________________

Primary Care Provider____

GUARANTOR INFO:

Guarantor Name______________________________ Relation to Patient______________________________

Date of Birth_________________________________ Phone# (   )________________________________

Insurance Card Copied: Yes / No

FINANCIAL POLICY

- Charges will be billed to the responsible patient/guarantor's insurance company only if you provide current and accurate insurance card at the time services are rendered.
- Guarantor will be responsible for any unpaid balance, if applicable, and must pay upon receipt of Explanation of Benefits (EOB) or upon receipt of invoice from TSMH.
- We accept cash, check, and credit/debit card for any outstanding balance after insurance.

Financial Consent: I have read the Financial Policy. I understand and agree to this policy. I also understand that I will be responsible for services considered as non-covered. I authorize release of medical information necessary to process medical claims and authorize payment of benefits to Tri-State Memorial Hospital.

CONSENT FOR RECEIVING INFLUENZA VACCINATION

I have been given the opportunity to review/read the VIS which contains the information about influenza and influenza vaccine. I understand the risks of the vaccine and possible side effects as outlined in that information. I am aware that the vaccine should not be administered to anyone with a history of allergy to chicken eggs or to any component of influenza vaccine, including Thimerosal, (mercury derivative) without first contacting a physician. I attest that I have not had a history of Guillain-Barre'syndrome. I deny any acute febrile illness today. I authorize the nurse to administer the influenza vaccine as described in the information I have read. I release the TSMH hospital of any responsibility for reactions or side effects I may experience.

REQUIRED SIGNATURE Patient / Guarantor:______________________________ Date_________________

HOSPITAL USE

LOT NO.: _______________EXPIRATION DATE: ____________BRAND: ___________________________

SITE OF INJECTION: _____R / L Deltoid__ GIVEN BY: ____________________________________

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