Oklahoma State Department of Health

Seasonal Influenza and Pneumococcal Data Entry Form

Please complete each field below with the information that applies to the client receiving services today.

Last Name	First Name	Middle Initial	Suffix (eg., Jr, III)	Age	Date of Birth

Street Address	City	State	Zip

Phone Number ( ) □ Cell □ Home	Gender □ Female □ Male □ Other	Ethnicity: Hispanic Origin □ Yes □ No	Race □ American Indian/Alaskan Native □ Asian □ Black/African American □ Native Hawaiian/Other Pacific Islander □ White □ Other

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Unknown

Primary Language ☐ English ☐ Spanish ☐ American Sign Language ☐ Other

State of Birth	Country of Birth	May we contact you? ☐ Yes, at address provided ☐ Yes, at phone provided ☐ No

If the client is under 18 years of age, please complete guardian information.

Guardian Relationship to Client: ☐ Father ☐ Mother ☐ Legal Guardian ☐ Other **Guardian Name (Last, First)**_____

Medical Insurance Information

Does client have health insurance? ☐ Yes ☐ No If yes, please provide insurance information below.

Please provide the following information: **Annual Household Income** $_____ **Number of people supported by income**_____

☐ **SoonerCare/ Medicaid**	SoonerCare/Medicaid Number	Member First and Last name as it appears on policy or card		Mother's Maiden Name	
☐ **Private Insurance**	Primary Insurance Co & EDI/Payer ID	Policyholder	Member Name Relation to Policyholder:	Member ID	Group Number
	Secondary Insurance Co & EDI/Payer ID	Policyholder	Member Name: Relation to Policyholder:	Member ID	Group Number
☐ **Medicare**	Do you have Medicare Part B? ☐ Yes ☐ No	Is Medicare Primary? ☐ Yes ☐ No		Medicare Number	

Consent for Service

I, the undersigned, give my consent for the services that I am requesting from the Oklahoma State Department of Health (OSDH) and its entities/contractors. I understand that the risks and benefits for these services will be explained to me and that I will have the opportunity to ask questions.

I also understand that:

- The information regarding myself and the services I receive will be entered into OSDH management information systems and may be used for program evaluation, management, and billing purposes.
- I will not be denied service because of my inability to pay.
- I may refuse service at any time.

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THIRD PARTY PAYMENTS: It is ultimately the client's responsibility to know your coverage and benefits. You may be responsible for any amount not covered by your insurance. If your insurance carrier denies any part of your claim, or if you elect to continue services past your coverage/policy period, you may be responsible for your balance in full.

- I authorize the OSDH to furnish information to my insurance carrier(s) concerning my care.
- I authorize my insurer(s) to pay any benefits directly to OSDH. I understand that any amount remaining after such payment has been made by my insurance carrier becomes my responsibility.
- I have read the above policy regarding my financial responsibility to OSDH for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate.

- I acknowledge that I have received a copy of the Oklahoma State Department of Health Privacy Statement as required by the Health Information Portability and Accountability Act (HIPAA). I can also find a copy of on the agency website.

Client/Guardian Signature: _____ Date: _____

Client Name: _____ Client Date of Birth (MM/DD/YYYY): _____ Date of Service: _____

Screening for Influenza and Provider Documentation

For adult patients and parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child an inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) 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
Is the person to be vaccinated sick today?	☐	☐	☐
Does the person to be vaccinated have an allergy to a component of the vaccine?	☐	☐	☐
Has the person to be vaccinated ever had a serious reaction to the influenza vaccine in the past?	☐	☐	☐
Has the person to be vaccinated ever had Guillain-Barre syndrome?	☐	☐	☐
Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, had an organ transplant, or any other immune system problem?	☐	☐	☐
Has the person to be vaccinated had a seizure or a brain or other nervous system problem?	☐	☐	☐

OFFICE USE ONLY – DO NOT WRITE BELOW				
Influenza Lot #: Exp. Date:		Site:		Provider Initials:
Pneumococcal Lot #: Exp. Date: Prevnar Lot #: Exp. Date:		Site:		Provider Initials:
0 – P.O.	3 – LT DELTOID IM	6 – LT UPPER ARM SQ	9 – OTHER	12 – RT DELTOID REG ID
1 – RT VAST LAT IM	4 – RT DELTOID IM	7 – RT GLUTEUS IM	10 – RT LEG	13 – LT DELTOID REG ID
2 – LT VAST LAT IM	5 – RT UPPER ARM SQ	8 – LT GLUTEUS IM	11 – LT LEG	