2016-2017 INFLUENZA DATA FORM.

Greeneville Urgent Care and IndustriCare Clinic Flu Vaccination Clinic

COMPANY: _____

LAST NAME: _____ FIRST NAME: _____ MI: _____ SS#: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ HOME PHONE: _____ ☐ MALE ☐ FEMALE Marital Status: S M W D

Insurance: _____ Subscriber Name: _____ Employer: _____

Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child Subscriber Date of Birth: _____

Subscriber Policy #: _____ Group#: _____ Subscriber SS#: _____

I have been given the opportunity to read and receive the information sheet entitled "Influenza Vaccine What You Need to Know 2016-2017 VIS 08/07/15" published by the U.S. Department of Health and Human Services, CDC, Public Health Service. I understand the risks and benefits of influenza vaccination. I desire to be vaccinated.

I hereby authorize the hospital and/or physicians to release to any appropriate insurance related entity or agency the information needed to process the claims in reference to this visit. I understand that payment is due in full at time of service and if not paid in full I am responsible to make the appropriate financial arrangements. Should my account become delinquent and be referred to any third party for collection effort, I agree to pay all reasonable attorneys fees, court costs and a collection expense of no more than 30 percent of referred balance. If applicable, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

Patient Signature: _____ Date: _____

***Please alert the nurse if you have allergies to chicken, eggs, gentamycin, neomycin, polymyxin, thimerosal, latex, or any allergies that you have.**

For Clinic Use Only

Date: _____

Allergies: _____

History of Guillian-Barre Syndrome: _____ Current Febrile Illness: _____ LMP: _____

Injection Site and Dose (Please Circle) : Right Left Deltoid 0.5 cc IM

Manufacturer: AFLURIA Lot Number: WT52906 Expiration Date: 06/07/2017

Signature of person administering vaccine: _____