PUTNAM COUNTY HEALTH DEPARTMENT
11878 WINFIELD ROAD, WINFIELD, WV 25213

IMMUNIZATION REGISTRATION FORM

SECTION 1. PATIENT INFORMATION

Patient's Name: _____ (Last) _____ (First) _____ (MI)

Current Address: _____ (Street)

_____ (City) _____ (State) _____ (Zip)

E-Mail (optional) _____

Home Phone _____ Work Phone _____ Cell Phone _____

_____ (Date of Birth) _____ (Age) ☐ Female ☐ Male _____ (Last 4 digits of Social Security #)

_____ (County of Residence) _____ (Race) _____ (Marital Status)

KCHD has permission to contact me by (Please check all that apply):

Home Phone ☐ Yes ☐ No Cell Phone ☐ Yes ☐ No Work Phone ☐ Yes ☐ No
Email ☐ Yes ☐ No

If Patient is under 18, please provide parent/guardian's name

Parent/Guardian's Name _____ (Last) _____ (First) _____ (MI)

SECTION 2. VACCINE FOR CHILDREN

Children 18 and under may qualify for state-supplied vaccine at a reduced rate. If the patient is **18 or under.** please complete this section of the form. If the patient is 19 or older, please proceed to Section 3 on next page

1. This child is privately insured ☐ Yes ☐ No
2. This child is enrolled in WVCHIP and qualifies for state-supplied vaccine ☐ Yes ☐ No
   a. If yes, please complete the WVCHIP information in Section 3 of this form
3. This child qualifies for Immunization through the VFC Program because he/she (check only one):
   - Is enrolled in Medicaid, if checked, provide Medicaid information in Section 3 of this form ☐
   - Does not have health insurance ☐
   - Is an American Indian or Alaskan Native ☐
   - Is underinsured (has health insurance that does not pay for vaccinations) ☐

Primary Physician's Name _____ (Last) _____ (First) _____ (MI)

TURN OVER AND COMPLETE OTHER SIDE

SECTION 3. INSURANCE- WV CHIP - MEDICAID INFORMATION

Name of Primary Insurance _____

Policy Holder's Name _____ Last _____ First _____ MI

Patient's relationship to Policy Holder ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER _____

Policy Number _____ Group number _____ Policy Holder's Date of Birth _____

Does Patient have secondary insurance? ☐ YES If yes, complete Secondary Insurance information
☐ NO If no, go to Section 4

Name of Secondary Insurance _____

Policy Holder's Name _____ Last _____ First _____ MI

Patient's relationship to Policy Holder ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER _____

Policy Number _____ Group number _____ Policy Holder's Date of Birth _____

SECTION 4. CONSENT

Submission of insurance information does not guarantee that the insurance company will cover the vaccine(s) given. If the insurance company does not cover the vaccine(s), the parent or legal guardian will be responsible for the charges.

I hereby grant permission to the Putnam County Health Department (PCHD) to have such diagnostic and/or treatment procedures performed on the patient named in this consent as may be deemed necessary by a duly authorized clinician of PCHD. I further grant authority to release such medical information regarding the above named patient as may be requested by other physicians or other health, welfare, or veterans agencies to which I have applied or may in the future apply for service or assistance.

The PCHD Notice of Privacy Practices provides information about how we may use and disclose your protected health information. The Notice of Privacy Practices is subject to change. To obtain a copy of our Notice, you may visit our website at www.pchd.wv.gov or by calling (304) 757-2541. By signing this form, you acknowledge that the PCHD Notice of Privacy Practices was made available to you.

You must be at least 18 years of age to sign. If under age 18, a parent or guardian's signature is required. By signing, you are stating the following for each vaccine selected: Vaccine Information Statements (VIS Forms) have been made available to me and I understand the information about the vaccine(s) I have chosen. I understand the benefits and risks of the vaccine(s) as well.

My signature on this document verifies that I have read and understand the information on this form. To the best of knowledge and belief, the information I have provided concerning income and insurance is true, correct and complete. Federal law prohibits falsification of this information.

In accordance with HIPAA guidelines, I _____ give permission to the following person(s) to obtain information about my medical records.
Patient name

_____

_____

_____

_____ _____ _____
Signature of Patient/Parent/ Legal Guardian Date Witness

PLEASE PROVIDE INSURANCE CARD AND PHOTO ID TO REGISTRATION FOR PHOTOCOPYING.