PAID M NM NO Ins

VISITING NURSE ASSOCIATION OF CAPE COD
Member Cape Cod Healthcare

Flu Vaccine Immunization Record

PLEASE PRINT

PLEASE PRINT NAME AS IT APPEARS ON INSURANCE/MEDICARE CARD

	(Last)	(First)	(MI)	Birth date:	Sex:
Name:				/ /	Male Female
St address:				age:	Phone:
City:				State:	Zip:
Medicare number: _ _ _ _ _ _ _ _ _ _ _ _				**Medicare PART B: YES NO**	
** **MUST** include the letter at the end and/or the beginning of the number					
Is Medicare primary insurance? YES NO					
All other Insurance information					
ACCEPTED INSURANCES: Aetna, BC/BS of MA, BMC, Fallon, HP, Masshealth, Tufts, Unicare/Comm Indemnity					

Primary Insurance Information (If not Medicare)

Insurance Name: _____ Is subscriber employed? Yes or No

Policy/ID number: _____ **suffix:** _____ **Group #** _____

*** **MUST include all letters in beginning/end of policy ID number**

Subscriber DOB: ___/___/___ Subscriber Sex: F M

Subscriber Name: _____

Patient relationship to Subscriber: Please Circle Spouse Child Other Self

Check here if you do not have Insurance →→→ ☐

Are you allergic to eggs	NO	YES	Are you allergic to Thimerosal (mercury)	NO	YES
Are you ill today	NO	YES	Have you ever had Guillian Barre Syndrome	NO	YES
Are you on anticoagulants	NO	YES	Have you ever had the Flu Shot	NO	YES
Are you allergic to latex	NO	YES	Are you allergic to neomycin/Polymyxin	NO	YES

By signing below I am giving my permission for my Insurance to be billed and confirm that I have been given a copy and have read or have had explained to me the information on the flu vaccine information sheet (08/7/2015).

_____ _____

Signature of person to receive vaccine or that persons guardian **Date**

DO NOT WRITE BELOW THIS LINE

Injection site: RD LD Nasal Nurses name: _____ Date administered: _____

Vaccine Name: _____ Vaccine Manufacturer: _____ Lot # _____

Provider name: VNA of Cape Cod, Inc _____

MDPH Provider PIN #

Clinic/office address: 255 Independence Drive, Hyannis MA 02601

Truro

name/location of clinic

Your signature above authorizes the release of protected health information pertaining to treatment, payment and operations necessary to this billing process, physicians, medical facilities, contracting provider, and community agencies involved in your care, quality review activities (internal and external, including regulatory and accrediting organizations), and release of outcome information to the state and center for Medicare and Medicaid Services, and Joint commission on Accreditation of Health Care Organizations.