



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 Vaccine
Name: _____ Manufacturer: _____ Lot # _____

Provider name: VNA of Cape Cod, Inc _____
Clinic/office address: 255 Independence Drive, Hyannis MA 02601 _____
MDPH Provider PIN #
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.