



DATE: _____

**DENTON COUNTY PUBLIC HEALTH
535 S. LOOP 288, SUITE 1003
DENTON, TEXAS 76205
940-349-2900 / FAX 877-865-2587**

PATIENT'S INFORMATION:

SS#: _____/_____/_____ MARITAL STATUS: __SINGLE __MARRIED

LAST NAME: _____ FIRST NAME: _____ MI: _____

SEX: __M __F DOB: _____/_____/_____ RACE: _____

RESIDENCY: __US CITIZEN __RESIDENT ALIEN __UNDOCUMENTED

BIRTH COUNTRY: _____ PREFERRED LANGUAGE: _____

MEDICAID #: _____ CHIP #: _____

CERTIFIED FOR SERVICES AS OF: _____/_____/_____

ADDRESS: _____ APT/LOT/TRLR# _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME #: (_____) _____ CELL#: (_____) _____

E-MAIL: _____

PREFERRED METHOD OF CONTACT: __HM# __CELL# __E-MAIL

PREFERRED PHARMACY: _____

IF MINOR (0-18 years):

ADULT RESPONSIBLE: _____ RELATIONSHIP: _____

MOTHER'S NAME: _____ DOB: _____/_____/_____

FATHER'S NAME: _____ DOB: _____/_____/_____



GENERAL CONSENT AND DISCLOSURE

The information in this consent form is given so that you will be better informed about the health care services you will receive. After you are sure you understand the information which will be given about the services and, if you agree to receive the services, you must sign this form to indicate that you understand and consent to the services.

NOTIFICATION: Denton County Public Health
(Name of Health Department)

(Hereafter called the Department) encourages individuals to seek a personal physician for periodic health examinations and for treatment of health problems. The Department clinic services are targeted primarily toward prevention of health problems among those who cannot access a physician. The Department cannot assume the responsibility for payment of medical care received outside this clinic, including the delivery of babies, unless previous written authorization has been given.

DISCLAIMER ON SCREENING: The Department uses screening tests, which are a way to find people who may develop certain common medical problems. Screening tests are valuable because they can find disease early-before it becomes a big health problem. Screening tests do not cover all diseases and may miss some diseases they are supposed to find, so the test results are not final, just one part of a complete exam. Screening tests can alert you to promptly get a medical check-up and treatment from a doctor or health clinic of your choice.

GENERAL CONSENT: I give permission to the Department, its designated staff and other medical personnel providing services under its sponsorship to perform physical assessments or examinations, conduct laboratory or other tests (which may include HIV testing), give injections, medications, and other treatments, and render other health services to the patient identified on this form.

ADDITIONAL CONSENT: In addition to the above general consent, I understand that special consent forms must be read and signed for the following procedures: medications for tuberculosis and Hansen’s disease, immunizations and family planning methods.

PRIVACY NOTICE: I acknowledge that I have received a copy of the Department’s HIPAA Privacy Notice.

QUESTIONS: I certify that this form has been fully explained to me, that any blank lines have been filled in and that any questions I have had about the services have been answered to my satisfaction.

SIGNATURES: Fill blank lines with NA if not applicable.

Patient’s Name _____ Patient’s Signature _____

Person Authorized to Consent (if not patient) _____ Relationship _____

Signature _____ Date _____

I decline HIV testing at this time. If so, initial here: _____

SIGNATURES SECTION II: I certify that the person who has the power to consent cannot be contacted and has not previously objected to the service being requested.

Patient’s Name _____ N/A _____

Name of Person Giving Consent _____ N/A _____ Signature _____ N/A _____

Relationship to Patient _____ N/A _____ Date _____ N/A _____

Address _____ N/A _____

Phone Number _____ N/A _____

SIGNATURES SECTION III:

Counselor Signature _____ Date _____

Immunization Patient Eligibility Screening Record: Adult

NOTE: Knowingly falsifying information on this document constitutes fraud. By signing this form, I hereby attest that the information below is true and correct.



Name: _____
 Last Name First Name

Date of Birth: _____ / _____ / _____
 month day year

Please check the category that applies. Then, sign and date on the right.

I have Medicaid	I have private health insurance	I have NO health insurance	I have Medicare	Signature	Date	Verified by: (staff initials)	Clerical Staff Use Only: Program Eligibility		
							AIP	ASN	Private

Please circle family size:

1	2	3	4	5	6	7+
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Please circle monthly income:

\$0-1,772	\$1,772.01-1,915.00	\$2,392.01-2,585.00	\$3,011.01-3,255.00	\$3,631.01-3,925.00	\$4,251.01-4,595.00	\$4,871.01+
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MEDICAID:

Medicaid number: _____

Date of eligibility: _____

Check here if you are 19 years of age and have been referred to the Denton County Health Department to finish a vaccine series you began when you were 18 or younger and eligible for Texas Vaccines for Children (TVFC).

Referring Provider: _____

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME _____

DATE OF BIRTH _____ / _____ / _____
month day year

For patients: The following questions will help us determine which vaccines you may be given today. If you answer “yes” to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your health care provider to explain it.

	yes	no	don't know
1. Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction after receiving a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you had a seizure or a brain or other nervous system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you received any vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? yes no

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your health care provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your health care provider records all your vaccinations on it.