PHS
Pediatrics & Vaccine Clinic

RICARDO OCHOA, MD

SECTION A (*Please print clearly)*

Patient Name _____ Date of Birth _____ Age _____

Address: _____ City/State/Zip _____

Home Phone: (____) _____ Cell Phone: (____) _____ Social Security # _____

Email: _____ EMPLOYER: _____

FOR MINORS: Mother's Name _____ Birth Date _____

FOR MINORS: Father's Name _____ Birth Date _____

SECTION B (*These questions will help us determine your eligibility to receive services today)*

1. I want to receive the following: _____
2. Reason for services: _____
3. Is your childhood vaccine record available? ☐ YES ☐NO Are your adult vaccines up to date? ☐ YES ☐NO
4. Are you sick today? If yes, do you have a fever? ☐ YES ☐NO
5. Do you have allergies to medicine, food, or vaccines? If yes, please list : ☐ YES ☐NO
6. Have you had any serious allergic reaction to a vaccine? ☐ YES ☐NO
7. Are you taking injectable medication such as steroids, anticancer drug or radiation treatment? ☐ YES ☐NO
8. Have you had any vaccinations or skin tests in the past 4 weeks? If yes, please list : ☐ YES ☐NO
9. Do you have any long term health problems? If yes, please circle ☐ YES ☐NO
   Anemia Asthma Diabetes Heart/Kidney/Liver/Lung Disease Other: _____
10. Do you have seizures, brain disorders, or any other nervous system problems? ☐ YES ☐NO
11. Do you have a problem with your immune system, history of AIDS, bone morrow disease or tuberculosis? ☐ YES ☐NO
12. During the past year, have you received blood, blood products, or been given immune (gamma) globulin? ☐ YES ☐NO
13. Are you 65 years or older? ☐ YES ☐NO
14. Do you smoke? ☐ YES ☐NO Do you drink? ☐ YES ☐NO Do you travel internationally? ☐ YES ☐NO
15. Are you currently enrolled in college or college courses? ☐ YES ☐NO
16. **Males & Females 9-26**: Are you interested in receiving the HPV-Human Papilloma Virus vaccine today? ☐ YES ☐NO
17. **For Women**: Are you pregnant or considering becoming pregnant in the next month? # of wks_____ ☐ YES ☐NO
18. How did you hear about us? _____

Temp:_____ Weight:_____ Height:_____ BMI:_____ BP:_____ Pulse:_____ Resp. Rate _____

SECTION C (*Consents/Authorizations)*

I acknowledge that PHS-PREVENTIVE HEALTH SOLUTIONS LLC has made available and or explained a copy of the VIS(Vaccine Information Statement) that contains information about the vaccine(s) including information on certain adverse reactions that I may experience as a result of receiving vaccine(s). I have had an opportunity to ask PHS-PREVENTIVE HEALTH SOLUTIONS LLC any questions about the vaccine(s) or about information in the Vaccine Information Statement. I have truthfully answered all the questions regarding my medical history that is listed above.

I further authorize PHS-PREVENTIVE HEALTH SOLUTIONS LLC to 1) release my medical or other information, including my communicable disease (HIV), mental health and drug/alcohol abuse information, to my healthcare professionals, Medicare, Medicaid, or other third party payer as necessary to effectuate care or payment, 2) submit a claim to my insurer for the requested items and services, and 3) request payment of authorized benefits be made on my behalf to PHS with respect to the requested items and services.

I authorize PHS-PREVENTIVE HEALTH SOLUTIONS LLC to submit a claim to my insurer for this health care service and authorize an assignment of my insurance benefits under such claim to PHS-PREVENTIVE HEALTH SOLUTIONS LLC. **I AM AWARE THAT PHS WILL BE CHARGING FOR VACCINES, VACCINE ADMINISTRATIONS, AND IN CERTAIN CASES, PERFORMANCE CODES REQUIRED BY CERTAIN INSURANCES.** I agree to be fully financially responsible for any co-sharing amounts, including copays, coinsurances, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if PHS invoices me after the time of service, upon receipt of such invoice.

PHS-PREVENTIVE HEALTH SOLUTIONS LLC shall not, at any time, or to any extent allowable by applicable law, be liable, responsible, or in any way be accountable for any loss, injury, death, or damage suffered or sustained by me or any other person at any time in connection with, or as a result of, the administration of the vaccine(s) to me by PHS-PREVENTIVE HEALTH SOLUTIONS LLC. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless PHS, its staff, agents, employees and corporate affiliates, officers, directors, contractors, and employees from any and all liabilities or claims whether known or unknown arising out of , in connection with, or in any way related to the administration of the vaccine(s) received.

By signing below, I certify that I am the patient of at least 18 years of age or the patient's guardian/personal representative signing on behalf of the patient, and that I have read, understand and agree to all the statements on this form.

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

PRINTED NAME: _____ **RELATIONSHIP (IF OTHER THAN PATIENT)** _____

REVISED 06/29/2017