Fast Track Immunization Clinic
Onslow County Health Department (OCHD)
612 College St., Jacksonville, NC 28540 (910) 347-2154

For OCHD Use

A. PATIENT'S PERSONAL DATA

Printed Name (Last, First MI, Generation)		**Birth Date**		**Age**	
Sex: ◯ Male ◯ Female	**SSN**		Hispanic Origin?	◯ Yes ◯ No	

To assist in client de-duplication process in N.C. immunization Registry (NCIR) provide Mother's Maiden Last Name, First Name MI:

Race: ◯ White ◯ Black ◯ American Indian ◯ Asian ◯ Native Hawaiian/Other Pacific Islander ◯ Unknown

Complete Mailing Address:

Home Phone:		Cell Phone:		Work Phone:	

B. HEALTH INSURANCE INFORMATION (Attach a copy of the front and back of your insurance card(s), if applicable

◯ Uninsured ◯ Bill Employer: *(Attach Employer's Authorization Letter)*

Primary Insurance Name:		Policy #	
Primary Subscriber Name:		Primary Subscriber DOB:	

Patient's Relationship to Subscriber: ◯ Self ◯ Spouse ◯ Child ◯ Other:

Secondary Insurance Name:		Policy #	
Secondary Subscriber Name:		Secondary Subscriber DOB:	

Patient's Relationship to Subscriber: ◯ Self ◯ Spouse ◯ Child ◯ Other:

Assignment of Insurance Benefits: When applicable, I, the patient name above, or the patient's authorized representative, understand that I may be financially responsible to OCHD for charges not covered by my medical insurance carrier(s). I agree to repay OCHD any money I receive from my medical insurance carrier for services provided to me by OCHD for which I have not paid. In addition, I authorize payment of medical benefits to OCHD on my behalf for services provided, unless other arrangements have been made. I authorize the use of this signature on all insurance submissions whether manual or electronic.

Signature (Parent or Legal Representative) *x*		Date	

C. STATEMENT OF CONSENT TO VACCINE

By my signature below, I show that I am legally authorized to give this consent and I:
- Have received the "Vaccine Information Statements" about the disease(s) and vaccine(s).
- Have had a chance to review the statements and to ask questions that were answered to my satisfaction.
- Understand the benefits and risks of the vaccine(s).
- Request the vaccine(s) indicated below be given to me or the person named above.

Printed Name		Signature *x*		Date	

D. ALLERGIES / COMMENTS:

E. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I am acknowledging that:
- I am either the patient or the patient's personal representative;
- I have received a copy of the "Notice of Privacy Practices" for **Onslow** County Health Department from OCHD; and
- I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

Printed Name (Patient / Parent / Legal Representative)	*x* Signature (Patient / Parent / Legal Representative)	Relationship to Patient	Date

TO BE COMPLETED BY OCHD STAFF

Part 1. Complete if signature requested but not obtained:

Staff member sought but was unable to obtain an acknowledgment from the patient or the patient's personal representative for the following reason:

☐ Patient / personal representative refused to sign form ☐ Other: _____

Part 2. Complete if patient / personal representative unavailable to sign form on first date of service of delivery:

☐ Form mailed / sent to patient / personal representative on: _____ DATE

Part 3. Complete if either Part 1 or Part 2 completed:

_____ Signature of Staff Member _____ DATE

Patient's Printed Name (Last, First MI, Generation) _____

Patient's Birth Date _____

ONSLOW COUNTY HEALTH DEPARTMENT (OCHD)
Fast Track Immunization Clinic

F. SHOT(S) ADMINISTERED (Section below to be completed by OCHD

Administration:	____ 90471 EP injection #1	____ 90472 EP + add. injection	* ____ 90473 EP intranasal ONLY	____ 90474 EP + add. intranasal / oral

☐ 99211 25 Travel Counseling (Z71.89). **NOTE**: Services/vaccines provided for international travel are / may not be covered by your insurance.

CPT	VACCINE DESCRIPTION	STATE/ PURCH		DX	ADMIN SITE		MANUFACTURER & LOT #	VIS
☐ 90702	DT (PEDS)	S	P	Z23	L	R		05/17/07
☐ 90700	Dtap	S	P	Z23	L	R		05/17/17
☐ 90662 [1]	Flu, High Dose (≥ 65 YO)		P	Z23	L	R		07/26/13
☐ 90672	Flu, Mist (2 YO - 49 YO)	S	P	Z23	NARES			07/26/13
☐ 90686	Flu, Quadrivalent > 19 yo, pregnant	S		Z23	L	R		07/26/13
☐ 90685	Flu, Quadrivalent (6-35 MOS) PF 0.25 mL	S		Z23	L	R		07/26/13
☐ 90686	Flu, Quadrivalent (36 MOS - 18 YO) PF 0.5 mL	S		Z23	L	R		07/26/13
☐ 90687	Flu, Quadrivalent (6 - 35 MOS) (5mL vial) 0.25 mL		P	Z23	L	R		07/26/13
☐ 90688	Flu, Quadrivalent (≥ 36 MOS) (5 mL vial) 0.5 mL		P	Z23	L	R		07/26/13
☐ 90633	HEP A (1 YO - 18 YO)	S	P	Z23	L	R		10/25/11
☐ 90632	HEP A (≥ 19 YO)	S	P	Z23	L	R		10/25/11
☐ 90744	HEP B, PEDS / ADOLESCENT (3)	S	P	Z23	L	R		02/02/12
☐ 90746	HEP B (≥ 20 YO) HIGH RISK? YES, BILL CAID	S	P	Z23	L	R		02/02/12
☐ 90647	HIB (PEDVAX) (3)	S	P	Z23	L	R		02/04/14
☐ 90651 [2]	HPV (GARDASIL 9) (9 YO - 26 YO) (3)	S	P	Z23	L	R		04/15/15
☐ 90713	IPV (≥ 2 MOS)	S	P	Z23	L	R		11/08/11
☐ 90738	JAPANESE ENCEPHALITIS		P	Z23	L	R		01/24/14
☐ 90696	KINRIX (DTAP / IPV) (≥ 4 YO - 6 YO)	S	P	Z23	L	R		11/08/11
☐ 90734	MENINGOCOCCAL (9 MOS - 55 YO)	S	P	Z23	L	R		10/14/11
☐ 90707	MMR (≥ 1 YO)	S	P	Z23	L	R		04/20/12
☐ 90723	PEDIARIX (2 MOS - 7 YO)	S	P	Z23	L	R		11/16/12
☐ 90698	PENTACEL (≥ 2 MOS - 4 YO)	S	P	Z23	L	R		11/16/12
☐ 90732	PNEUMONIA (≥ 2 YO) (HIGH RISK)	S	P	Z23	L	R		10/06/09
☐ 90670	PREVNAR (PCV13) (2 MOS - 6 YO OR > 65 YO)	S	P	Z23	L	R		02/27/13
☐ 90710	PROQUAD / MMRV (2 YO - 12 YO)	S	P	Z23	L	R		05/21/10
☐ 90675	RABIES, IM	S	P	Z23 & Z20.3	L	R		10/06/09
☐ 90680	ROTAVIRUS	S	P	Z23	ORAL			08/26/13
☐ 90714	TD (TETANUS) (≥ 7 YO)	S	P	Z23	L	R		02/04/14
☐ 90715	TDAP (≥ 10 YO)	S	P	Z23	L	R		05/09/13
☐ 90636	TWINRIX	S	P	Z23	L	R		02/02/12
☐ 90691	TYPHOID		P	Z23	L	R		05/29/12
☐ 90716	VARICELLA (≥ 1 YO)	S	P	Z23	L	R		03/13/08
☐ 90717	YELLOW FEVER		P	Z23	L	R		03/30/11
☐ 90736 [3]	ZOSTAVAX (≥ 60 YO)		P	Z23	L	R		10/06/09

* Currently, 90473 can ONLY be billed if the intranasal / oral vaccine is the only immunization provided on that DOS.

[1] Medicaid do NOT pay for high dose flu.

[2] The series must be complete prior to the 19th birthday. Medicaid/Tricare do NOT pay for HPV vaccine nor administration for those > 20 yo.

[3] Medicaid/ Medicare do NOT pay for Zostavax (Shingles). While others may pay based on CDC's age recommendations.

G. SHOT(S) ADMINISTERED BY

	Provider's Signature	Provider ID	Date	Data Entry Purposes	
I have asked about prior immunizations and reactions. According to informant, no reactions have occurred.	X			☐ NCIR	☐ HIS