CLINIC REGISTRATION FORM

www.scphoh.org
1867 West Market Street ♦ Akron, Ohio 44313-6901
Phone: (330) 923-4891 ♦ Toll-free: 1 (877) 687-0002 ♦ Fax: 330-752-7925

Date:_____

Reason for Visit:
☐Received a post card ☐Received a phone call ☐New patient ☐Return visit

How did you hear about us:_____

Patient Information:
Last Name:_____ First Name: _____Middle Initial: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone Number: ( )_____ E-Mail Address: _____
Are you currently homeless, residing in a shelter, or currently have no fixed address? ☐Yes ☐No
Date of Birth: ____/____/_____ Age:_____ ☐Male ☐Female Social Security Number:_____-____-_____
Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
Mark all that apply: ☐ African American ☐ Caucasian ☐Asian ☐Hispanic ☐American Indian/Alaskan Native ☐Other_____
In Case of Emergency, who should be notified? _____
Phone: ( ) _____ Relationship: _____
Doctor's Name: _____ Phone number: _____

Insurance information
☐ I have insurance coverage
☐ I have no insurance coverage
Does your insurance cover immunizations? ☐Yes ☐ No
Would you like a Medicaid application? ☐ Yes ☐ No

Primary Insurance Coverage
Name and Address of insurance company _____ Effective date____/____/_____
Name of person on card _____ SS #_____-_____-_____ Birth date____/____/_____
ID # on card _____ Group # on card _____

Secondary Insurance Coverage
Name and Address of insurance company _____ Effective date____/____/_____
Name of person on card _____SS #_____-_____-_____ Birth date____/____/____
ID # on card _____ Group # on card _____

I understand that the charges for today's visit will be submitted to my insurance company for payment and that any balance not paid for by my insurance is my responsibility to pay. Initial_____

☐ Please check this box if you would like information about other resources or programs offered in our community. (If you have specific needs for your family, you may list them below and a nurse will be happy to help you when you are seen)

I acknowledge that I have been offered a copy of the Notice of Privacy Practices

_____

Client or Guardian Signature **Date**

SUMMIT COUNTY PUBLIC HEALTH
1867 West Market Street ♦ Akron, Ohio 44313-6901
Phone: (330) 923-4891 ♦ Toll-free: 1 (877) 687-0002 ♦ Fax: (330) 752-7925
www.scphoh.org

PATIENT CONTACT DIRECTIVES

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: ____/____/____ Phone Number (Home/Cell)_____ Language:_____

Patient Privacy Directives
In our efforts to comply with the health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

Do we have permission to:
Contact you on the number listed above to discuss appointments, treatment or test results?
☐Yes ☐No

Leave a message regarding appointments on the number listed above?
☐Yes ☐No

Would you like us to text health information to you? (Encoded STD test results only)
☐Yes ☐No

*Would you like us to share health or payment information with close friends or relatives, directly involved with your care?
☐Yes ☐No

If yes:

*Please provide us with a name and phone number that we may leave messages regarding **appointments:**
Name:_____ Number:_____ (Home/Cell//Email)

Relationship to Patient _____

*Please provide us with a name and phone number that we may leave a message regarding **treatments and/or test results.**
Name:_____ Number:_____ (Home/Cell/Email)

Relationship to Patient_____

*Do you have any other specific instructions/requests about how we should communicate with you or others about your appointments, treatment, or test results?_____
_____

I acknowledge that all information above is accurate. You must inform us **in writing** of any changes in your directives.

_____ _____ ____/____/_____
Signature Printed Name Date

PATIENT:_____

DATE OF BIRTH:_____

VITAL SIGNS: REFERRED TO PCP_____
WT: _____TEMP:_____BP:_____/_____
PULSE:_____RESPIRATIONS:_____

Screening Checklist for Contraindications to Vaccines for Adults

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 healthcare provider to explain it.

	Yes	No	Don't Know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
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.	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs: drugs for the treatment of rheumatoid arthritis, Crohn's disease or psoriasis: or have you had radiation treatments?	☐	☐	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
8. During the past year, have you received a transfusion of blood of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
9. For women: Are you pregnant or is there a chance you could become Pregnant during the next month?	☐	☐	☐
10. Have you received vaccinations in the past 4 weeks?	☐	☐	☐

11. List all of the prescriptions and over the counter medications you are taking and why:

_____ _____ _____

_____ _____ _____

Form completed by:_____ Date:_____

Form reviewed by: _____ Date:_____

Did you bring your immunization record with you? ☐ Yes ☐ No

Technical content reviewed by the Centers for Disease Control and Prevention

Information for Healthcare Professionals about the Screening Checklist for Contraindications to Vaccines for Adults

Are you interested in knowing why we included a certain question on the screening checklist? If so, read the information below. If you want to find out even more, consult the references listed at the end.

1. Are you sick today? *[all vaccines]*

There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events.[1] However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (such as upper respiratory infections or diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics.

2. Do you have allergies to medications, food, a vaccine component, or latex? *[all vaccines]*

An anaphylactic reaction to latex is a contraindication to vaccines that contain latex as a component or as part of the packaging (e.g., vial stoppers, prefilled syringe plungers, prefilled syringe caps). If a person has anaphylaxis after eating gelatin, do not administer vaccines containing gelatin. A local reaction to a prior vaccine dose or vaccine component, including latex, is not a contraindication to a subsequent dose or vaccine containing that component. For information on vaccines supplied in vials or syringes containing latex, see reference 2; for an extensive list of vaccine components, see reference 3.

People with egg allergy of any severity can receive any recommended influenza vaccine (i.e., any IIV or RIV) that is otherwise appropriate for the patient's age. For people with a history of severe allergic reaction to egg involving any symptom other than hives (e.g., angioedema, respiratory distress), or who required epinephrine or another emergency medical intervention, the vaccine should be administered in a medical setting, such as a clinic, health department, or physician office. Vaccine administration should be supervised by a healthcare provider who is able to recognize and manage severe allergic conditions.[4]

3. Have you ever had a serious reaction after receiving a vaccination? *[all vaccines]*

History of anaphylactic reaction (see question 2) to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses.[1] Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk (e.g., during a community pertussis outbreak).

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? *[LAIV]*

The safety of intranasal live attenuated influenza vaccine (LAIV) in people with these conditions has not been established. These conditions, including asthma in adults, should be considered precautions for the use of LAIV.

5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? *[LAIV, MMR, VAR, ZOS]*

Live virus vaccines (e.g., LAIV, measles-mumps-rubella [MMR], varicella [VAR], zoster [ZOS]) are usually contraindicated in immunocompromised people. However, there are exceptions. For example, MMR vaccine is recommended and varicella vaccine should be considered for adults with CD4+ T-lymphocyte counts of greater than or equal to 200 cells/μL. Immunosuppressed people should not receive LAIV. For details, consult the ACIP recommendations.[4,5,6]

6. In the past 3 months, have you taken medications that affect your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments? *[LAIV, MMR, VAR, ZOS]*

Live virus vaccines (e.g., LAIV, MMR, VAR, ZOS) should be postponed until after chemotherapy or long-term high-dose steroid therapy has ended. For details and length of time to postpone, consult the ACIP statement.[1,5] Some immune mediator and immune modulator drugs (especially the antitumor-necrosis factor agents adalimumab, infliximab, and etanercept) may be immunosuppressive. The use of live vaccines should be avoided in persons taking these drugs (*MMWR* 2011;60 [RR-2]:23). To find specific vaccination schedules for stem cell transplant (bone marrow transplant) patients, see reference 7. LAIV can be given only to healthy non-pregnant people ages 2 through 49 years.

NOTE: Live attenuated influenza vaccine (LAIV4; FluMist), is not recommended by CDC's Advisory Committee on Immunization Practices for use in the U.S. during the 2016–17 influenza season. Because LAIV4 is still a licensed vaccine that might be available and that some providers might elect to use, for informational purposes, reference is made to previous recommendations for its use.

7. Have you had a seizure or a brain or other nervous system problem? *[influenza, Td/Tdap]*

Tdap is contraindicated in people who have a history of encephalopathy within 7 days following DTP/DTaP given before age 7 years. An unstable progressive neurologic problem is a precaution to the use of Tdap. For people with stable neurologic disorders (including seizures) unrelated to vaccination, or for people with a family history of seizure, vaccinate as usual. A history of Guillain-Barré syndrome (GBS) is a consideration with the following: 1) Td/Tdap: if GBS has occurred within 6 weeks of a tetanus-containing vaccine and decision is made to continue vaccination, give Tdap instead of Td if no history of prior Tdap; 2) Influenza vaccine (IIV/LAIV): if GBS has occurred within 6 weeks of a prior influenza vaccine, vaccinate with IIV if at increased risk for severe influenza complications.

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? *[LAIV, MMR, VAR, ZOS]*

Certain live virus vaccines (e.g., LAIV, MMR, VAR, ZOS) may need to be deferred, depending on several variables. Consult the most current ACIP recommendations for current information on intervals between antiviral drugs, immune globulin or blood product administration and live virus vaccines.[1]

9. For women: Are you pregnant or is there a chance you could become pregnant during the next month? *[HPV, IPV, MMR, LAIV, VAR, ZOS]*

Live virus vaccines (e.g., MMR, VAR, ZOS, LAIV) are contraindicated one month before and during pregnancy because of the theoretical risk of virus transmission to the fetus. Sexually active women in their childbearing years who receive live virus vaccines should be instructed to practice careful contraception for one month following receipt of the vaccine. On theoretical grounds, inactivated poliovirus vaccine should not be given during pregnancy; however, it may be given if risk of exposure is imminent and immediate protection is needed (e.g., travel to endemic areas). Inactivated influenza vaccine and Tdap are both recommended during pregnancy. Both vaccines may be given at any time during pregnancy but the preferred time for Tdap administration is at 27–36 weeks' gestation. HPV vaccine is not recommended during pregnancy.[1,4,5,6,8,9]

10. Have you received any vaccinations in the past 4 weeks? *[LAIV, MMR, VAR, yellow fever, ZOS]*

People who were given either LAIV or an injectable live virus vaccine (e.g., MMR, VAR, ZOS, yellow fever) should wait 28 days before receiving another vaccination of this type. Inactivated vaccines may be given at any spacing interval if they are not administered simultaneously.

REFERENCES

1. CDC. General recommendations on immunization, at www.cdc.gov/mmwr/pdf/rr/rr6002.pdf.
2. Latex in Vaccine Packaging: www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/latex-table.pdf.
3. Table of Vaccine Components: www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf.
4. CDC. Prevention and control of seasonal influenza with vaccines: Recommendations of the Advisory Committee on Immunization Practices – United States, 2016–17 influenza season at www.cdc.gov/mmwr/volumes/pdf/65/rr/pdfs/rr6505.pdf, pages 1–56.
5. CDC. Measles, mumps, and rubella – vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps. *MMWR* 1998; 47 (RR-8).
6. CDC. Prevention of varicella: Recommendations of the Advisory Committee on Immunization Practices. *MMWR* 2007; 56 (RR-4).
7. Tomblyn M, Einsele H, et al. Guidelines for preventing infectious complications among hematopoietic stem cell transplant recipients: a global perspective. Biol Blood Marrow Transplant 15:1143–1238, 2009 at www.cdc.gov/vaccines/pubs/hemato-cell-transplts.htm.
8. CDC. Notice to readers: Revised ACIP recommendation for avoiding pregnancy after receiving a rubella-containing vaccine. *MMWR* 2001, 50 (49).
9. CDC. Updated recommendations for use of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap) in pregnant women: Recommendations of the ACIP. *MMWR* 2012; 62 (7):131–4.

Summit County Public Health
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NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how your medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Compliance With Other Laws

Other provisions of law may apply to your information. If any state or federal privacy laws require us to provide you with more privacy protections than those explained here, then we must also follow that law. For example, drug and alcohol treatment records are subject to the following restrictions:

- Information regarding participation in a treatment program or identifying a patient as a substance abuser will not be disclosed except as permitted by applicable law.