

PATIENT REGISTRATION (REGISTRO DE PACIENTE)

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Nombre			A Liveria in	MEMICO
Date of Birth		Social Security #		
Fecha de Nacimiento	Female/Mujer	# Seguro Social		
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Nother/Guardian		D.O.B.	SS#	
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Insurance		ffective Date	Address	
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Health History

Joints

Name of Patient			Name of Pen	son Completing Form		
Date		Relationship to Patient				
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Sex O Male	Race	2	Social Security #		ров	
O Female		cirkfyllik:		\cdot . J	1 1	

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	Name	***	DOB	Occupation	Education	
Father:						
Mother:						
Other:						
Other:						
Other:				,	2000000	
Other:						
lave there recently	been any major cha	anges or stresses in t	the child's life?) Yes□ O No		
		tter, pre-school or day	y care? ○ Yes□	O No		
T. 20 1						
s your child expos	ed to cigarette smok	e? O Yes: O No				
s your child expos			1	A		
BIRTH HIST		e? O Yes: O No	<u></u>	t.		
• • BIRTH HIST	ORY • • •	- March 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		34		
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Repeated Infections O Yes O No

lave any of the child's blood relatives had the fo	ollowing diseases? If YES, please list f	amily member.
Heart disease	O Yes□ O No	
Tuberculosis	O Yes O No	
High Blood Pressure	O Yes□ O No	
Kidney Disease	O Yes□ O No	
Allergies/Asthma	O Yes□ O No	15 ₃ - 1
Cancer	O Yes□ O No	
Diabetes	O Yes□ O No	
Mental/Emotional Problems	O Yes□ O No	
Sickle Cell	O Yes□ O No	
Selzures	O Yes□ O No	
• DEVELOPEMENT • • •		
you have any concerns about the following?	If YES, please explain.	•
Developement		
Behavior	O Yes∃ O No	
Eating Habits	O Yes□ O No	
Sleeping Habitts	O Yes□ O No	
School Experience	O Yes□	
Bathroom/Toilet Habits	O Yes□ O No	
Discipline	O Yes□ O No	
Other (explain)	O Yes O No	
• This Section is for Teenagers and is	to Completed by the Teenager	Notes:
o you:	to completed by the reemage.	Notes.
se Tabacco?	O Yes□ O No	İ
ink Beer or other Alcoholic Beverages?	3 3	
se any kind of drugs?	O Yes II O No.	1
or Females) How old were you when you had	your first period?	
e you sexually active?	O Yes□ O No	
YES, do you use birth control?	O Yes□ O No	
ave you ever been pregnant or fathered a child	f? O Yes□ O No	
you have any concerns about the following?		
fety Issues	O Yes O No	
ibstance Use (drugs, alcohol, tabacco)	O Yes□ O No	1
exually transmitted Diseases	O Yes□ O No	
amily Planning	O Yes O No	
ther (explain)	O Yes□ O No	
ı		

Date

Reviewed By

Vaccines for Children (VFC) Program Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations must be kept in the health care provider's office for 6 years. The record may be completed by the parent, guardian, individual of record, or by the health care provider. VFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine. Providers using a similar form (paper-based or electronic) must capture all reporting elements included in this form.

VIII	mai form (pape	or basea or ciccito	ino) musi capture a	an reporting elem	ents included in this	iom.		
1.	Child's Name	East Name		First)	Vame		MI	
2.	Child's Date	of Birth:/						
3.	Parent/Guard	dian/Individual of R	ecord:					
			Last Name		First Name		MI	
4.	Primary Provi	7			1 de la companya de l			
		Last N		First I	Name		MI	
5.	immunization	encounter/visit en	h 18 years of age) ter the date and ma or G is marked th	is eligible to rece ark the appropriat	ive federal vaccine te eligibility categor ible for federal VFC	y. If Column A- vaccine.	C and state progra D is marked, the che eligible for VFC	ild is eligible for
		Av	Lag B	The last of a second second second	D	i E		G
	Date	Medicaid Enrolled	No Health Insurance	First N American Indian or Alaskan Native	arne *Underinsured served by FQHC, RHC or deputized provider	Has health insurance that covers vaccines	**Other underinsured	***Enrolled in KidsCare
					ac'is:			
covei Clinic progr	red by Insurance. (RHC) or under a am in order to vac	In addition, to receive an approved deputized ccinate underinsured co	VFC vaccine, underinst provider. The deputize hildren.	ured children must be ed provider must hav	only covers specific vacc a vaccinated through a l e a written agreement v	Federally Qualified vith an FQHC/RHC	Health Center (FQHC) and the state/local/tem	or Rural Health itorial immunization
** Oti FQH	ner underinsured a C/RHC or a deput	are children that are un ized provider? Howeve	nderinsured but are not er, these children may b	eligible to receive fe be sêrvêd if vaccines	deral vaccine through th are provided by the stat	e VFC program be has he thin te program to cove	cause the provider or for these non-VFC eligible	ecility is not a e children.
***Ch orogr	ildren enrolled in : am. Each state p	separate state Childrei rovides specific guidar.	n's Health Insurance Pr ace on how CHIP vacci	rogram (CHIP). Thes ne is purchased and	e children are considen administered through pa	ed insured and are articipating provide	not eligible for vaccine: rs.	s through the VFC
	se be advised:		1 1					
nvol	ved. We cannot	t make the Vaccines	s for Children Progr	ram retroactive an	t us know at the time d you are only eligib	le for the Vacci	es for Children Pro	ty to pay the cost
Char	ik You.	· Lusure A Humuni			d, please contact you		pany.	
Pleas	e sign below in	dicating that you un	derstand and agree			,		