Immunizations Data Entry Form

Please complete each field below with the information that applies to the client receiving services today. ***If client is a minor, please sign the Consent in both places if parent/legal guardian is not present with minor at visit.***

Last Name	First Name	Middle Initial	Suffix (eg., Jr, III)	Age	Date of Birth

Street Address	City	State	Zip	Phone Number ( ) ☐ Cell ☐ Home

Hispanic Origin ☐ Yes ☐ No

Race ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Unknown

Primary Language ☐ English ☐ Spanish ☐ American Sign Language ☐ Other

Gender ☐ Female ☐ Male ☐ Other | **State of Birth** | **Country of Birth** | **May we contact you?** ☐ Yes, at address provided ☐ Yes, at phone provided ☐ No

If the client is under 18 years of age, please complete guardian information.*

Guardian Relationship to Client: ☐ Father ☐ Mother ☐ Legal Guardian ☐ Other **Guardian Name (Last, First)**______________________________

Medical Insurance and Household Income Information

Does client have health insurance? ☐ Yes ☐ No **Annual Household Income $** ______________ **Number of people supported by income**______

☐ **SoonerCare/ Medicaid**	SoonerCare/Medicaid Number	Member First and Last name as it appears on policy or card		Mother's Maiden Name	
☐ **Private Insurance**	Primary Insurance Co & EDI/Payer ID	Policyholder	Client Relation to Policyholder	Member ID	Group Number
	Secondary Insurance Co & EDI/Payer ID	Policyholder	Client Relation to Policyholder	Member ID	Group Number
☐ **Medicare**	Do you have Medicare Part B? ☐ Yes ☐ No	Is Medicare Primary? ☐ Yes ☐ No		Medicare Number	

Consent for Service

I, the undersigned, give my consent for the services that I am requesting from the Oklahoma State Department of Health (OSDH) and its entities/contractors. I understand that the risks and benefits for these services will be explained to me and that I will have the opportunity to ask questions. I also understand that:

- The information regarding myself and the services I receive will be entered into OSDH management information systems and may be used for program evaluation, management, and billing purposes.
- I will not be denied service because of my inability to pay.
- I may refuse service at any time.

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THIRD-PARTY PAYMENTS: It is ultimately the client's responsibility to know your coverage and benefits. You may be responsible for any amount not covered by your insurance. If your insurance carrier denies any part of your claim, or if you elect to continue services past your coverage/policy period, you may be responsible for your balance in full.

- I authorize the OSDH to furnish information to my insurance carrier(s) concerning my care.
- I authorize my insurer(s) to pay any benefits directly to OSDH. I understand that any amount remaining after such payment has been made by my insurance carrier becomes my responsibility.
- I have read the above policy regarding my financial responsibility to OSDH for providing medical services to me or the above-named patient. I certify that the information is, to the best of my knowledge, true and accurate.
- I acknowledge that I have received a copy of the Oklahoma State Department of Health Privacy Statement as required by the Health Information Portability and Accountability Act (HIPAA). I can also find a copy on the agency website.

Client/Guardian Signature:______________________________ Date: ______________

For clients less than 18 years old without a parent/guardian present:

I consent for my child/ward to receive the provider's recommended vaccines today without my presence, and understand if my child is not cooperative, vaccines will not be given. In the event of an emergency situation, emergency medications and/or oxygen may be administered to my child.

Parent/Guardian Signature: ______________________________ Date: ______________

Client Name: ____ Client Date of Birth (MM/DD/YYYY): ___________________ Date of Service: ________________

OFFICE USE ONLY – DO NOT WRITE BELOW			
VACCINE NAME: Lot #: Exp. Date:	Site:	VIS given? Y N Reaction? Y N	Provider Signature:
VACCINE NAME: Lot #: Exp. Date:	Site:	VIS given? Y N Reaction? Y N	Provider Signature:
VACCINE NAME: Lot #: Exp. Date:	Site:	VIS given? Y N Reaction? Y N	Provider Signature:
VACCINE NAME: Lot #: Exp. Date:	Site:	VIS given? Y N Reaction? Y N	Provider Signature:
VACCINE NAME: Lot #: Exp. Date:	Site:	VIS given? Y N Reaction? Y N	Provider Signature:
VACCINE NAME: Lot #: Exp. Date:	Site:	VIS given? Y N Reaction? Y N	Provider Signature:
(Circle one) JSN / MOD / MOD 6mo / MOD 6-11yr / PFR / PFR 6mo / PFR 5-11yr / NVX Lot #: Exp. Date:	Site: Dose: 1 2 3 B	EUA/VIS given? Y N Reaction? Y N	Provider Signature:

0 – P.O.	1 – RT VAST LAT IM	2 – LT VAST LAT IM	3 – LT DELTOID IM	4 – RT DELTOID IM	5 – RT UPPER ARM SQ	6 – LT UPPER ARM SQ	7 – RT GLUTEUS IM
8 – LT GLUTEUS IM	9 – OTHER	10 – RT LEG	11 – LT LEG	12 – RT DELT REG ID	13 – LT DELT REG ID	14 - NASAL	15 – RT FOREARM ID
16 – RT LOW FOREARM ID	17 – LT FOREARM ID	18 – LT LOW FOREARM ID					

Immunizations BCD for ***Monkeypox Vaccine only*** --- Jynneos SDV/MDV ______________ (Service Code ID 3289)
(Provider initials)