# Patient Registration Form

**(Please Print Clearly)**

**NAME:** _____
Last First M.I.

**EMAIL:** _____ **BIRTH DATE:**____/_____/____

**SEX:** □ Male □ Female **RACE/ETHNIC:** □ White □ African-Amer. □ Asian □ Hispanic/Latino □ Other

**ADDRESS:**_____
No. Street Apt. City State Zip

**PHONE:** □HOME □OFFICE ( ) _____-_____ **CELL:** ( _ ) _____-_____

**EMERGENCY CONTACT** _____ _____ _____
Name Relationship Phone

**ALLERGIES** to foods or medicines: _____

**HOW DID YOU LEARN ABOUT IMU: (**CHECK ALL THAT APPLY**)**

□ I have been here before □ Referred by my doctor/clinic (name, phone) _____

□ Web search □ Referred by my school/employer (name)_____

□ Ad □ Referred by my friend/family/other (name) _____

## Consent for Medical Care, Record Keeping, Privacy Notice, and Payment Responsibility

I, as the client/patient, agree to receive care from a health care provider at The Immunization Clinic. I give consent for examination, immunization, blood or skin testing, medical advice, and other services from my clinic provider. (2) I understand that it is my responsibility to pay for services received. (3) I acknowledge that I have had the opportunity to read or receive a copy of the "Notice of Privacy Practices" (posted). (4) I understand that IMU email transmission may not be secure against unauthorized disclosure, and I hereby authorize that the clinic may send my health information to me via unsecure email, but only upon my specific request to receive such information by email. (5) The Immunization Clinic will keep this record in you or your child's medical file. It records what vaccine(s) and/or test(s) were given, the date when the vaccine(s) and/or test(s) were given, the name of the company that made the vaccine(s) and/or test(s), the lot number of the vaccine(s) and/or test(s), and the address where the vaccine(s) and/or test(s) were administered. (6) By signing the form below, you hereby freely and voluntarily give your permission and are requesting that the vaccine(s) and/or test(s) indicated by your signature(s) below be given to you or the person named below for whom you are authorized to make this request. (7) I understand the risks and benefits of the test/vaccine being given to me and have had the opportunity to read The Vaccine Information Sheet "VIS" on each vaccine, or a "Subject Information" pamphlet on each test, as stated by law, for me to read BEFORE I receive your shots and/or test(s). Your signature below indicates that you have read,or have had the information explained to you and that you understand the benefits and risks of each vaccine administered. You hereby release and agree to hold harmless The IMU Southwest Clinic, its Officers, and Employees for all liability, of any kind or nature whatsoever, which might arise out of or result from any vaccine(s) and/or test(s) administered to you or your child.

Signed: _____ Date:_____

**If client is a minor:**

Print name of parent/ guardian: _____

Signature of parent/guardian:_____ Date: _____

**For Clinic/Office Use Only Vaccine Information Statements (VISs) as of February 28, 2020**

| | | | | | |
|---|---|---|---|---|---|
| Varicella 8/15/19 | DTap 4/1/20 | Hib 10/30/19 | Hepatitis A 7/28/20 | Cholera 10/30/19 | Influenza 8/15/19 |
| Polio 10/30/19 | PCV 13 10/30/19 | MMR 8/15/19 | Hepatitis B 8/15/19 | Gardasil 10/30/19 | Shingles 10/30/19 |
| Rabies 1/08/20 | PPSV 10/30/19 | MMRV 8/15/19 | MCV4 8/15/19<br>MenB 8/15/19 | Japanese Enceph 8/15/19 | Typhoid 10/30/19 |
| Td 4/1/20<br>Tdap 4/1/20 | Yellow Fever 4/1/20 | TB Skin Test/PPD | Multi-Vaccine 4/1/20 | Rotavirus 10/30/19 | Titers/Other: |