



Oklahoma State
Department of Health

Seasonal Influenza and Pneumococcal Data Entry Form

Please complete each field below with the information that applies to the client receiving services today.

Last Name		First Name		Middle Initial	Suffix (eg., Jr, III)	Age	Date of Birth
Street Address				City		State	Zip
Phone Number () () <input type="checkbox"/> Cell <input type="checkbox"/> Home		Gender <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other		Ethnicity: Hispanic Origin <input type="checkbox"/> Yes <input type="checkbox"/> No		Race <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Unknown				Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> American Sign Language <input type="checkbox"/> Other			
State of Birth		Country of Birth		May we contact you? <input type="checkbox"/> Yes, at address provided <input type="checkbox"/> Yes, at phone provided <input type="checkbox"/> No			
If the client is under 18 years of age, please complete guardian information.							
Guardian Relationship to Client: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other				Guardian Name (Last, First) _____			
Medical Insurance Information							
Does client have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide insurance information below.							
Please provide the following information: Annual Household Income \$ _____ Number of people supported by income _____							
<input type="checkbox"/> SoonerCare/Medicaid	SoonerCare/Medicaid Number		Member First and Last name as it appears on policy or card			Mother's Maiden Name	
<input type="checkbox"/> Private Insurance	Primary Insurance Co & EDI/Payer ID		Policyholder	Member Name		Member ID	Group Number
	Secondary Insurance Co & EDI/Payer ID		Policyholder	Member Name:		Member ID	Group Number
<input type="checkbox"/> Medicare	Do you have Medicare Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No			Is Medicare Primary? <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare Number	
Consent for Service							
<p>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.</p> <p>I also understand that:</p> <ul style="list-style-type: none"> • 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. <p>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.</p> <ul style="list-style-type: none"> - 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 of on the agency website. 							
Client/Guardian Signature: _____				Date: _____			

Client Name: _____

Client Date of Birth (MM/DD/YYYY): _____

Date of Service: _____

Screening for Influenza and Provider Documentation

For adult patients and parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child an inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) 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
Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the person to be vaccinated have an allergy to a component of the vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the person to be vaccinated ever had a serious reaction to the influenza vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the person to be vaccinated ever had Guillain-Barre syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, had an organ transplant, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the person to be vaccinated had a seizure or a brain or other nervous system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OFFICE USE ONLY – DO NOT WRITE BELOW

Influenza Lot #: Exp. Date:		Site:		Provider Initials:	
Pneumococcal Lot #: Exp. Date:		Site:		Provider Initials:	
Prevnar Lot #: Exp. Date:					
0 – P.O.	3 – LT DELTOID IM	6 – LT UPPER ARM SQ	9 – OTHER	12 – RT DELTOID REG ID	
1 – RT VAST LAT IM	4 – RT DELTOID IM	7 – RT GLUTEUS IM	10 – RT LEG	13 – LT DELTOID REG ID	
2 – LT VAST LAT IM	5 – RT UPPER ARM SQ	8 – LT GLUTEUS IM	11 – LT LEG		