MONROE COUNTY DEPT OF PUBLIC HEALTH
IMMUNIZATION CLINIC
111 WESTFALL RD ROCHESTER, NY 14620 585-753-5150

#_____

_____
Initials

Please fill out all known information.

☐ **NAME:** _____ **SEX:** _____ **DOB:** _____/_____/____
Last Name First Name Month Day Year

☐ **ADDRESS:** _____
House # Street State Zip Code Telephone Number

☐ **PARENT/GUARDIAN WITH CHILD < 18 YEARS: (Print name)** _____

☐ **SCHOOL:** _____
*****If applicable*****

☐ **FOR CHILDREN BIRTH - 18 YRS, MOTHER'S MAIDEN NAME: (Print name)** _____
(for identification purposes)

☐ **DOCTOR/HEALTH CARE PROVIDER:** _____
*****If no Doctor/Healthcare provider, please write "none"*****

☐ **Name or Practice/ Address:** _____

☐ **INSURANCE NAME:** _____
*****If no Health Insurance, please write "none"*****

☐ **Subscriber ID#:** _____

☐ **Name of Subscriber:** _____ **Relationship to Patient:** _____

☐ **Preferred Language:**_____ **Country of Origin:**_____

Label

Staff Use ONLY

Clinic staff should check (√) all that apply every visit. If fees / co-pays are charged to adults at time of visit, please indicate amount.

*VFC or VFA Eligibility(VFA codes for use are 2 or 4 only)	Insurance	NYS >18 ADULT	ADULT Grant or VFA	% SFS / Fee ADULT	Merck ADULT (Use Red Dot vaccine)	Full Fee ADULT	Interpreter service (minutes used)	NYSIIS, HIPPA & Vaccine Consent signed
A 1 2 3 4 5 6								

*VFC Eligibility:(A) Adult; (1)Medicaid /Managed Care; (2)Uninsured; (3)American Indian/Alaskan Native; (4)Underinsured; (5) **Commercially Insured (NOT ELIGIBLE)**; (6) Child Health Plus B

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