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VISITING NURSE ASSOCIATION OF CAPE COD
Member Cape Cod Healthcare

# Flu Vaccine Immunization Record

**PLEASE PRINT**

**PLEASE PRINT NAME AS IT APPEARS ON INSURANCE/MEDICARE CARD**

| | (Last) | (First) | (MI) | Birth date: | Sex: |
|---|---|---|---|---|---|
| Name: | | | | / / | Male Female |
| St address: | | | | age: | Phone: |
| City: | | | | State: | Zip: |
| **Medicare number**: __ __ __ __ __ __ __ __ __ __ __ | | | | **Medicare PART B: YES NO** | |
| ** **MUST** include the letter at the end and/or the beginning of the number | | | | | |
| **Is Medicare primary insurance?** YES NO | | | | | |
| **All other Insurance information** | | | | | |
| **ACCEPTED INSURANCES**: Aetna, BC/BS of MA, BMC, Fallon, HP, Masshealth, Tufts, Unicare/Comm Indemnity | | | | | |

## Primary Insurance Information (If not Medicare)

Insurance Name: _____ Is subscriber employed? Yes or No

**Policy/ID number:** _____ **suffix:** _____ **Group #** _____

*** **MUST include all letters in beginning/end of policy ID number**

Subscriber DOB: / / Subscriber Sex: F M

Subscriber Name: _____

Patient relationship to Subscriber: Please Circle Spouse Child Other Self

**Check here if you do not have Insurance →→→** ☐

| | | | | | |
|---|---|---|---|---|---|
| Are you allergic to eggs | NO | YES | Are you allergic to Thimerosal (mercury) | NO | YES |
| Are you ill today | NO | YES | Have you ever had Guillian Barre Syndrome | NO | YES |
| Are you on anticoagulants | NO | YES | Have you ever had the Flu Shot | NO | YES |
| Are you allergic to latex | NO | YES | Are you allergic to neomycin/Polymyxin | NO | YES |

By signing below I am giving my permission for my Insurance to be billed and confirm that I have been given a copy and have read or have had explained to me the information on the flu vaccine information sheet (08/7/2015).

_____ _____

**Signature of person to receive vaccine or that persons guardian** **Date**

**DO NOT WRITE BELOW THIS LINE**

Injection site: RD LD Nasal Nurses name: _____ Date administered: _____

Vaccine Name: _____ Vaccine Manufacturer: _____ Lot # _____

Provider name: VNA of Cape Cod, Inc _____

MDPH Provider PIN #

Clinic/office address: 255 Independence Drive, Hyannis MA 02601

_____

name/location of clinic

Your signature above authorizes the release of protected health information pertaining to treatment, payment and operations necessary to this billing process, physicians, medical facilities, contracting provider, and community agencies involved in your care, quality review activities (internal and external, including regulatory and accrediting organizations), and release of outcome information to the state and center for Medicare and Medicaid Services, and Joint commission on Accreditation of Health Care Organizations.