

Please Print

Last Name				First Name				Middle Initial			
Date of Birth	MM	DD	YY	Age	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Phone Number ()				
Address: Street					City			State		Zip	

This section is to be completed ONLY if we are billing your insurance. Co-payment may apply. *We do not accept Kaiser.*

- ☐ Medicare Part B (Primary Plan) ☐ Other: _____ Payer ID _____
☐ DCSD (Cigna) ☐ AETNA ✓ Eligibility ☐ CNIC ☐ Cofinity ☐ Humana (not HMOx) ☐ Rocky Mtn. Health Plans

Print Name exactly as it appears on insurance card: _____

Member ID # Including any letter(s) before or after number: _____

Patient Relationship to Primary Insured: ☐ Self ☐ Spouse* ☐ Child* ☐ Other*

*Primary Insured Name: _____ Date of Birth _____ Member ID _____ ☐ Male ☐ Female
 Address if different than above: _____

Answer the following questions, sign and date below:

- | | | |
|---|-----|----|
| 1. Have you ever had a flu immunization before? | Yes | No |
| 2. Do you have a history of hypersensitivity (allergy) to chicken eggs or egg protein? | Yes | No |
| 3. Have you ever had an adverse or allergic reaction to any component of the vaccine, including thimerosal? | Yes | No |
| 4. Do you currently have a fever, or moderate or severe acute illness with or without fever? | Yes | No |
| 5. Do you have a history of Guillain-Barre Syndrome (a severe paralytic disease, also called GBS)? | Yes | No |
| 6. Have you ever had a bad reaction to any other vaccine? | Yes | No |

Explain any adverse or allergic reactions: _____

FluMist Nasal Spray ONLY: Continue & Complete 7 – 12. You must be healthy, 4 - 49 years old, and not pregnant.

- | | | |
|---|-----|----|
| 7. How old are you? _____ Are you pregnant or nursing? | Yes | No |
| 8. Have you received any vaccines within the last month or do you plan to receive any within the next month? | Yes | No |
| 9. Are you in close contact with severely immunocompromised individuals requiring a protective environment (such as bone marrow transplant recipients)? | Yes | No |
| 10. Are you under 18 and on long-term aspirin treatment? | Yes | No |
| 11. Are you taking Tamiflu® (oseltamivir), Relenza® (zanamivir), amantadine, or rimantadine? | Yes | No |
| 12. Do you have any of the following illnesses or conditions: Chronic lung disease including asthma, reactive airway disease, one or more episodes of wheezing within the past year, nasal condition serious enough to make breathing difficult, a very stuffy nose, weakened immune system, HIV, currently taking medications that can weaken your immune system, heart disease, kidney or liver disease, diabetes, muscle or nerve disorder that can lead to breathing or swallowing problems, seizure disorder, Cerebral Palsy, anemia, blood disorders, long-term health problems, and / or hypersensitivity (allergy) to Gentamicin, Gelatin, Arginine, MSG. | Yes | No |

Explain: _____

* The current applicable *Influenza Vaccine Information Statement* has been provided to me. I have read or have had explained to me the information. I have had an opportunity to review FRFS's *Notice of Privacy Practices* and am aware that I can request a copy. I have had a chance to ask questions and, if any, they were answered to my satisfaction. Upon request, a receipt or copy of this form can be sent to me or an authorized person via mail, email, or fax. I believe I understand the benefits and risks of the vaccine and I ask that the vaccine be given to me or to the person named for whom I am authorized to make this request. I agree that Front Range Flu Shots, LLC shall have no responsibility or liability if I or the named person contract influenza or any other respiratory diseases or suffer any adverse reaction following administration of the vaccine.

* I understand that I am responsible for payment to Front Range Flu Shots, LLC if vaccination is not fully covered by insurance company.

* I understand there is a \$25 fee for returned checks.

Signature of Responsible Person: _____ **Date:** _____

Insurance Coding and Billing Information for Influenza Vaccination						Do not write below this line.	
Front Range Flu Shots, LLC • P.O. Box 1093, Littleton, CO 80160-1093 • Phone 303-797-3396 Federal Tax ID: 743077363						VIS Provided: Inactivated Influenza Vaccine 08/19/2014 Live Attenuated Influenza Vaccine 08/19/2014	
Influenza Type	Trivalent Shot	Quadrivalent Shot	Fluzone High Dose Shot	FluMist Nasal Spray	Amount Paid	Injection site (0.50mL)	RN
Service Location:	60	60	60	60		____ Left Deltoid	____ Date
Diagnosis Code:	V04.81	V04.81	V04.81	V04.81		____ Right Deltoid	Mfg
Vaccine Admin. Code:	G0008	G0008	G0008	90473	\$ _____	Intra-nasal (0.2mL)	Lot #
Vaccine Code:	90658	<input type="checkbox"/> 90686 (S) <input type="checkbox"/> 90688 (M)	90662	90672	\$ _____	____ Nasal Spray	Exp. Date
Clinic Location:							

MC RRMC MED ADV DCSD Aetna CNIC Cofinity Humana RMHC Comp CC Check _____ Cash _____ Invoice _____

Email: _____ CC Name, Type, #, Exp. Code

09.02.14