

DATE: \_\_\_\_\_

**ADULT FORM**

Rev 9/24

TIME: \_\_\_\_\_ INITIALS: \_\_\_\_\_

OFFICE STAFF ONLY

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MAIDEN: \_\_\_\_\_

(AS IT APPEARS ON THE BIRTH CERTIFICATE)

ADDRESS: \_\_\_\_\_ APT#: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

COUNTY: \_\_\_\_\_ PHONE #: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SEX: F / M  
MTH DAY YR

COUNTRY OF BIRTH: \_\_\_\_\_ RACE: WHITE BLACK AMERICAN INDIAN ALSKA NATIVE ASIAN OTHER  
ETHNICITY: (CIRCLE) HISPANIC OR LATINO NOT HISPANIC OR LATINO

YES	NO	MEDICAL HISTORY
		ARE YOU SICK TODAY?
		ANY ALLERGIES TO FOODS, MEDICATIONS, VACCINE COMPONENTS, OR LATEX?
		HAVE YOU EVER HAD A SERIOUS REACTION AFTER RECEIVING A VACCINE?
		DO YOU FAINT WHEN GETTING VACCINATED?
		ANY OF THE FOLLOWING: HEART DISEASE, LUNG DISEASE, ASTHMA, KIDNEY DISEASE, ANEMIA, DIABETES?
		ANY OF THE FOLLOWING: CANCER, LEUKEMIA, AIDS, OR ANY OTHER IMMUNE SYSTEM DISORDER?
		DO YOU TAKE CORTISONE, PREDNISONE, OTHER STEROIDS, ANTICANCER DRUGS, OR HAVE YOU HAD RADIATION TREATMENTS?
		HAVE YOU HAD A SEIZURE OR A BRAIN OR NERVOUS SYSTEM PROBLEM?
		HAVE YOU RECEIVED A BLOOD TRANSFUSIONS, ANY BLOOD PRODUCTS OR BEEN GIVEN GAMMA GLOBULIN OR AN ANTIVIRAL DRUG?
		HAVE YOU RECEIVED ANY VACCINES DURING THE PAST 4 WEEKS? IF YES, WHAT DID YOU GET:
		HAVE YOU HAD CHICKEN POX (VARICELLA)? YES OR NO APPROXIMATE MONTH, DATE, AND YEAR OF DISEASE: _____ / _____ / _____
		ANY MEDICAL CONDITIONS THAT WE NEED TO BE AWARE OF:
		<b>FEMALES:</b> IS THERE A CHANCE THAT YOU COULD BE PREGNANT OR BECOME PREGNANT DURING THE NEXT MONTH? LAST MENSTRUAL PERIOD?

NURSES SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**Disclosure of Protected Health Information**

Our commitment here at CCNCPHD is to serve our customers with professionalism and care, being sure at all times to protect the privacy and security of all Protected Health Information. During the course of serving your interests it may be necessary to share information with other healthcare providers or business associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire a laboratory analysis.
- For payment purposes, we may use the services of a billing service.
- During healthcare operations, we may need a second opinion and may consult with a subcontractor / physician, or need to share information between departments within the Health Department for future programs made available for improving patient care / health issues.

We here at CCNCPHD are committed to obeying all Federal, State, and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures that the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for the law. If you have any questions or comments regarding your protected health information, feel free to contact our Compliance Officer. I have read and understand the above Notice of Privacy Practices.

I HAVE COMPLETED AND REVIEWED ALL INFORMATION ABOVE.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

PRINT: \_\_\_\_\_

IF YOU HAVE PRIVATE INSURANCE INCLUDING MEDICAID AND MEDICARE, PLEASE BE ADVISED THAT YOU DO NOT QUALIFY FOR VACCINES UNDER THE TEXAS ADULT SAFETY PROGRAM (ASN). WE DO HAVE VACCINES AVAILABLE UNDER PRIVATE PAY. CHECK WITH STAFF FOR PRICES OF PRIVATE VACCINE.