MIDLAND COUNTY HEALTH DEPARTMENT
FAMILY PLANNING/ CD CLINICS
CONFIDENTIAL PERSONAL INFORMATION

Name: _____ DOB:_____ Age:_____
(Last) (First) (MI)

Address:_____

Phone: (Home)_____ (Other)_____

Please list any other names you may have used at the Health Department._____

I have read and verify that the above information is correct. Client's initials_____

Marital Status:(S)_____(M)_____(W)_____(D)_____(Sep)_____

Circle the last grade completed: 6 7 8 9 10 11 12 13 14 15 16+

CONTACT INFORMATION:

It may be necessary to contact you if a test result indicates a potential or serious health risk or to cancel/reschedule an appointment. Check ***all*** acceptable ways the clinic may use to contact you. *You must pick at least one way to be contacted*. If we are unable to contact you by your preferred method, you will be mailed information in a plain envelope.

____ OK to say Health Department or "Kathy" is calling
____ OK to call or leave a message at home Number_____Hours_____
____ OK to call/leave message on pager/cell phone #_____
____OK to be contacted by other means: (work) Number _____
(school) Number _____
(e-mail) Address_____

HEALTH INSURANCE INFORMATION:

Do you have Public Health Insurance coverage like Medicaid? (Yes) (No) (Unknown)
Do you have Private Health Insurance through a parent, employer, union, direct purchase (Yes) (No) (Unknown)
Does your insurance cover all or some Family Planning Services? (Yes) (No) (Unknown)

There are fees for all services. If you do not have Public Health Insurance, (Medicaid or Medicare) the charge for the services that you receive is discounted based on your income and family size.

Please fill out the following portion (A) or (B) based on age.

(A) Under 18:

Are both, your mother and father and/or guardian aware of your receiving services here? (Y) (N)
If **YES**, what is the *household* total income before taxes? Circle one week, month, year $_____
How many people, including yourself, are supported by this income? _____
If **NO,** what is your income from allowance, part time job, etc.? $_____

(B) Ages 18 and Over- Do NOT Include Parent's Income:

What is the *household* total income before taxes? Circle one week, month, year $_____
How many people, including yourself, are supported by this income? _____
(Household income includes spouse or partner. If you are not employed, give your spouse/partner income)

I verify that the above information is accurate:_____
Client Signature **Date**

Clinic Use Only

DATE	$ PER YEAR	% TO PAY	INITIALS

Midland County Health Department
Consent for Services and Release of Information

Client Name:_____ DOB: _____ Age:_____

Midland County Health Department, its employees or agents may provide applicable services, examination and/or diagnostic testing or treatment. These services are provided confidentially, on a voluntary basis, without my being forced to accept any services or medications.

I understand that information from my record may be shared with the members of my treatment team. My treatment team will be determined by the services I receive, and may include, but is not limited to, a nurse, nurse practitioner, or doctor. In the event of an infestation or infection of a school-aged child, my child's school may be contacted. Childhood immunizations may be shared with the Michigan Childhood Immunization Registry. Any other release of information will require a specific release, signed by the client, custodial parent or guardian, unless the information is otherwise legally required.

I understand that I do not need to receive family planning services to get other services or support from the health department.

Midland County Health Department may release, either verbally or in writing, information contained in my medical, social, or educational records, including HIV, AIDS, or AIDS related information, as is necessary for the authorization and payment of bills for professional services.

I understand that I am responsible for charges due the Health Department and that payment is expected at the time of service.

If a Health Department employee is exposed to blood or body fluids by puncture, or consent to open skin or mucus membrane, the client's blood may be tested for HIV and other infectious diseases without further consent.

As a partner in my health care, I understand that participation and follow through is expected. Services may be terminated due to noncompliance. Examples of noncompliance are: not being at home two times for scheduled home visits, failure to pay fees for which I am responsible, or failure to follow a prescribed treatment.

This authorization will continue in effect through the duration of service associated with this admission or condition, up to one year, or until revoked in writing.

Print Name of the Person authorizing consent:

_____

Custodial Parent, Guardian or Client (circle one)_____

Signature:_____**Today's Date**_____

Clerk's Initials_____

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME _____

DATE OF BIRTH ____/____/____
month / day / year

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you 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
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. Do you have a parent, brother, or sister with an immune system problem?	☐	☐	☐
7. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☐	☐
8. Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
9. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
10. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
11. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? yes ☐ no ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

immunization action coalition
IAC
immunize.org

Saint Paul, Minnesota · 651-647-9009 · www.immunize.org · www.vaccineinformation.org

www.immunize.org/catg.d/p4065.pdf · Item #P4065 (6/20)

Midland County
Department of Public Health

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I was provided with a copy of the Midland County Department of Public Health Notice of Privacy Practices.

_____	_____	_____
Patient Name (Print)	Patient Signature	Date

If completed by a patient's personal representative, please print and sign your name in the space below

_____	_____	_____
Personal Representative (Print)	Personal Representative's Signature	Date

_____
Relationship

For Midland County Department of Public Health use only

Complete this section if this form is not signed and dated by the patient or patient's personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Midland County Department of Public Health Notice of Privacy Practices Acknowledgement, but was unable for the following reason:

_____

_____	_____
Employee name	Date

This form should be placed in the patient's medical record