



MINERAL COUNTY  
Health Department

# Face Sheet

## Patient Demographic Information

**Patient Name:** \_\_\_\_\_

Please Print (last name) First name (Given Name) MI  
**Patent Gender:** (Circle one) **Male** **Female** **Date of Birth:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_ **APT #** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_ **APT #** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Phone: (Home)** \_\_\_\_\_ **Cell:** \_\_\_\_\_ **Work:** \_\_\_\_\_

**E-Mail:** \_\_\_\_\_ **Social Security # (optional)** \_\_\_\_\_

**Primary Care Physician/Clinic (if applicable):** \_\_\_\_\_

**Race:** (circle) Caucasian Asian/Pacific Islander Hispanic African American American Indian Other \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Current Medications:** \_\_\_\_\_

**If patient is under the age of 18:**

**Full name of parent or Legal Representative:** \_\_\_\_\_

**Address if different from patient's address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Day Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

### Insurance

\_\_\_\_ None/Self Pay

\_\_\_\_ **PRIMARY Insurance Co. Name:** \_\_\_\_\_

**Policy Holder (Insured's Name):** \_\_\_\_\_ **Policy Holder Date of Birth:** \_\_\_\_\_

**ID Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**What relationship is Policy Holder to the Patent (circle one):** Self Child Other: \_\_\_\_\_

**Is Policy through Employer (Circle one):** Yes No **If yes, Employer's Name:** \_\_\_\_\_

**Effective Date of Policy:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Does your insurance cover vaccines? (circle one):** Yes  No **Comments:** \_\_\_\_\_

### Preferred way of contact

\_\_\_\_ Yes, Mineral County Health Department has my permission to leave messages in regard to appointments.

**My preferred way to received messages is:**

**Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_ **Text:** \_\_\_\_\_

## Acknowledgement and Consent

I acknowledge that the information on face sheet is accurate (circle):            Yes            No  
Has the patients insurance changed from what is listed on previous page? (circle): Yes    No

*(If information on face sheet has changed please ask for new form)*

**(Please initial, included the italicized statements if receiving immunizations)**

\_\_\_\_ I consent to receive services provided by the personnel at Mineral County Health Department.

\_\_\_\_ I have received and reviewed the Notice of Privacy Practices, which provides a description of information uses and disclosures.

\_\_\_\_ I authorize payment of medical benefits to this county health department for services rendered.

\_\_\_\_ I understand that the patient/parent or responsible party is responsible for any unpaid balances

\_\_\_\_ I have read or have had explained to me information contained in the Vaccine Information Statement(s) about the disease(s) and the vaccine(s). I have had a chance to ask questions which were **answered to my satisfaction.**

\_\_\_\_ I understand the benefits and risk of the vaccine(s) and request the vaccine(s) to the person named above for whom I am authorized to make this request.

\_\_\_\_ I authorize my health care provider and public health agency to collect and enter my or my child's immunization records into the Department of Public Health and Human Service Immunization Information System (IIS). *The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my or my child's medical care and treatment. In addition, information may be released to child care facilities and schools in which my child is enrolled to comply with state immunization requirements.*

I understand that I can revoke this authorization and have my or my child's record removed at any time by contacting my local health department.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_