THREE RIVERS DISTRICT HEALTH DEPARTMENT
510 SOUTH MAIN, OWENTON, KY 40359

(Lab label with encounter #)

PATIENT REGISTRATION

PLEASE PRINT. (All items refer to the individuals for whom services are requested.) **COUNTY CODE:**_____

1._____ 2._____
LAST NAME **FIRST NAME** **MIDDLE INITIAL** **PATIENT ID NUMBER (SSN)**

3._____
(MAILING) ADDRESS **CITY** **COUNTY** **STATE** **ZIP CODE**

4. _____/_____/_____
BIRTHDATE

5. SEX (*check one*)
☐ **Female**
☐ **Male**

6. ETHNICITY (*check one*)
☐ **Y) Hispanic or Latino**
☐ **N) Not Hispanic or Latino**

7. RACE (*check one or more*)
☐ **W) White** ☐ **B) Black or African American** ☐ **N) American Indian or Alaska Native** ☐ **A) Asian** ☐ **H) Native Hawaiian or Other Pacific Islander**

8._____
Number in Household

9. (_____)_____
HOME PHONE NUMBER

Is it OK for us to phone, send mail or leave an automated telephone message to remind you of your appointment? ☐ **Yes** ☐ **No**

10. **MEDICAID NUMBER:** _____ **MCO:** Passport/Anthem/Humana/Aetna/Wellcare (circle one)
MCO NUMBER: _____

CONSENT FOR HEALTH SERVICES (Expires 1 year from date signed)
Of my own free will, I consent to care which may include screening, exams, lab tests, treatment, medicine, x-ray, and any other health service given to me by staff or agents of this health department. I understand that no Guarantees are being made as to the effect of any exam or treatment on me. I also understand I may be tested for (HIV) infection, Hepatitis B, or any other disease carried by blood or body fluids if such a test(s) is needed for diagnosis, to assist in my medical treatment, or if a health care worker is exposed to my blood, body fluids, or tissue.

WITNESS: _____ **X**_____ _____
(If patient cannot sign) **Signature of Patient or Other Authorized Person** **Date**

My signature below acknowledges my receipt of Three Rivers District Health Department's *"NOTICE OF PRIVACY PRACTICES"* on the date stated.

WITNESS: _____ **X**_____ _____
(If patient cannot sign) **Signature of Patient or Personal Representative** **Date**

INFORMED CONSENT FOR VACCINES

I read or had read to me information about the vaccines listed below. I had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) to be administered and ask that the vaccine(s) check be given to me or the patient.

☐**Hep A VIS Date:**__/__/__ ☐**Hep B VIS Date:**__/__/__ ☐**Meningococcal VIS Date:** __/__/__
☐**Tdap VIS Date:** __/__/__

Signature of Patient or Other Authorized Person X_____ **Date**_____

(Health Department Use Only) Place of Service: (M patient's home) (O other unlisted facility) (Health Department)

Type	*Site*		*Dosage*	*Manufacturer*	*Lot Number*
Hep A	Lt Deltoid	Rt Deltoid	1.0cc	GSK	
Tdap	Lt Deltoid	Rt Deltoid	0.5cc	SP/ GSK	
Meningoccal	Lt Deltoid	Rt Deltoid	0.5cc	GSK	
	Lt Deltoid	Rt Deltoid			

Provider Signature & Title:_____ **Provider #:**_____

CPT Codes:
__x__ 80000 Unspecified Procedure or Lab **ICD V069/ or Z23.**
__x__ 90460 Admin. Of 1 vaccine/toxoid (age 19 and Above)
_____ 90461 Admin. Of 2+ vaccine/toxoid (age 19 and Above)
_____ 90632 Hep A Adult
_____ 90715 Tdap
_____ **90734 Meningoccal**