Baylor Scott & White HEALTH

Flu Questionnaire 2021

New Patient to Baylor Scott and White?	□ No □ Yes
Is the Patient under the age of 18 years?	□ No □ Yes

Patient Last Name: ______________________________ **First:** ____________________________________

Gender: □M □F **Date of Birth:** ___/___/____ **Age:** _____ **Daytime Phone:** (___) ____-_______

Mailing Address: __________________________________ **City**_________________ **State**____ **Zip**________

Guarantor Name:____ **Date of Birth:** ___/___/____

Primary Care Physician: _____________________________

Medical Insurance (Mark X in one or more boxes that apply):

❑ **Insurance (not Medicare or Medicaid)**

Insurance Payor: ____________________

Policy Number: ______________________

Grp Number: _______________________

Primary Insured: _____________________

Policy Holder: _______________________

Policy Holder DOB:____________________

❑ **Medicaid/Texas Vaccines for Children Program**

❑Medicaid Number: ________________ Date of Eligibility: ________

OR ❑CHIP Number: ________________ Date of Eligibility: ________

OR ❑American Indian **OR** Alaska Native

OR ❑Is **underinsured***: **(Mark X in one of boxes below)**

- ❑ My child's commercial (private) insurance, but coverage does **not** include vaccines **OR**
- ❑ My commercial insurance covers only selected vaccines

❑ **Self-Pay**

❑ Cash $__________

❑ Credit Card *Visa MC Discover AmEx*

**Please provide card to attendant for processing. A receipt will be provided.*

Name on Card: ____________________

Billing Address: ❑ *Check box if same as mailing*

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❑ **Medicare**

Policy Number: ___________________________

Flu Vaccine*: If you answer any of the following questions "YES," you may not be eligible for flu vaccine today.*

1. Have you/your child already received the flu vaccine this year?	**Yes**	**No**
2. Have you/your child ever had a serious reaction/sensitivity to any flu vaccine?	**Yes**	**No**
3. Have you/your child ever been diagnosed with (Guillain-Barre' syndrome)?	**Yes**	**No**
4. Do you/your child have a severe allergy to eggs?	**Yes**	**No**
5. Bone marrow transplant within the past 6 months?	**Yes**	**No**
6. Have you felt ill today or yesterday or do you have a fever?	**Yes**	**No**
7. Do you/your child have anemia or a serious blood disorder?	**Yes**	**No**
8. Have you/your child received any live vaccines in the past 4 weeks?	**Yes**	**No**

E.g.: MMR, Chicken Pox or Zostovax (Shingles) If yes, which one/s: ____________________

Date/s given: ____________

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- By signing below, I attest that all answers above are true and correct to be best of my knowledge and that I have read and been provided a copy of the 2021 Vaccine Information Statement (VIS) for the 2021-2022 flu season. I further affirm that any and all questions I have that relate to receiving the influenza vaccine have been answered to my full satisfaction and I consent to receiving the 2021-2022 influenza vaccine at this time.

Patient/Parent Signature ______________________________ **Date**___________ **Time**_________

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For office use (Circle One): FLULAVAL QUAD FLUZONE QUAD

Administered by ______________________ **Date**_________ **Time**____:_______ **Site of Injection** **R L deltoid thigh**

Lot No. ________________ GSK Sanofi **Expiration date** _______________

Inactivated Flu VIS Sheet given? **Yes** **No** **Patient MRN**: __________________ **EMR Entry Name**: ___________________