CAMPUS HEALTH SERVICES UNIVERSITY OF LOUISVILLE
REGISTRATION FORM

(Please Print)

PATIENT INFORMATION			
Last Name:	First:	Middle:	Social Security number:
Preferred Name:	Student/Employee ID #:	Birth Date: ____/____/____	Sex: M ❑ F ❑ T ❑
Race:		Ethnicity: ❑ Hispanic ❑ Non-Hispanic	
Street address:			Home Phone Number (____) ____ - _____
City:	State:		ZIP Code:

INSURANCE INFORMATION		
Patient's Relationship to Subscriber: ❑ Self (If Self STOP -- no further information is needed) ❑ Spouse ❑ Child ❑ Other		
Subscriber's Name:		Subscriber's Birth Date: ____/____/____
Subscriber's Address (if different than above):		
Subscriber's Employer:	Subscriber's Home Phone Number:	
Primary Insurance Company's name:	Group Number	Policy Number

Health Services Office
University of Louisville
Louisville, KY 40292
Health Sciences Center Office (502) 852-6446
Belknap Campus (502) 852-6479

Consent for Medical Care and Release of Information

I wish to have treatment given to myself my child or ward by the University of Louisville Health Services Offices (hereafter known as "Health Services Office"). I hereby give myself my child's my ward's voluntarily consent to routine diagnostic and therapeutic procedures, such as physical exams, x-rays, vaccinations and laboratory tests. As the part of the care to be given, a test may be performed for human immunodeficiency virus infection (HIV/AIDS), hepatitis, or other blood-borne infections or communicable diseases if the doctor orders the test for DIAGNOSTIC purposes because of my/my child's/my ward's medical history, symptoms or clinical findings.

I fully understand that, as a courtesy to me, the Health Services Office will file my insurance claims. However, I am fully responsible for all bills incurred for services rendered. I will also be held responsible for all services not covered by insurance and payment is expected at the time of service. If payment is not received in a timely manner, I am aware that I may be turned over to a collection agency and reported to the credit bureau.

I hereby authorize the Health Services Office may share medical records and information with my health insurance carrier, as necessary to process insurance claims or payment for care provided. I further authorize payment of any health insurance benefits be made directly to the Health Service Office. I hereby acknowledge that I have read and fully understand the information set forth above and any questions have been answered to my satisfaction.

I hereby acknowledge that I have read and fully understand the Patient's Bill of Rights, which has been given to me.

Date: _____ Patient: _____

Date: _____ Witness: _____

Parents/Guardian Signatures

I hereby state that I am the parent legal guardian Other (specify: _____) of the patient and I am authorized to sign on their behalf.

Date: _____ Parent/Guardian: _____

Date: _____ Witness: _____

Campus Health Services
University of Louisville
Louisville, KY 40292

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

TO ACCEPT:

I acknowledge that I have been provided a copy of **Campus Health Services'** Notice of Privacy Practices:

_____ _____
Signature of Patient or Personal Representative Date

TO DECLINE:

I acknowledge that I declined **Campus Health Services'** Notice of Privacy Practices provided:

_____ _____
Signature of Patient or Personal Representative Date

Screening Questionnaire for Adult Immunization

Patient Name: _____

Date of Birth: _____ **UofL ID Number:** _____

Hepatitis A Vaccine # ____ **Injection Site: Left Deltoid** ____ **Right Deltoid** ____

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 for explanation.

1.	Are you sick today?	YES: _____	NO: _____
2.	Do you have allergies to medications, food or any vaccine?	YES: _____	NO: _____
3.	Have you ever had a serious reaction after a vaccination?	YES: _____	NO: _____
4.	Do you have a long term health problem: heart, lung, kidney metabolic disease, diabetes, anemia or blood disorder?	YES: _____	NO: _____
5.	Do you have cancer, leukemia, HIV or any immune system problem?	YES: _____	NO: _____
6.	Do you take cortisone, prednisone, other steroids, anticancer medication or have you had radiation treatment?	YES: _____	NO: _____
7.	Have you had a seizure, brain or nervous system problem?	YES: _____	NO: _____
8.	During the past year, have you received a transfusion of blood blood product, or been given immune globulin or antiviral?	YES: _____	NO: _____
9.	Have you received any vaccinations in the last four weeks?	YES: _____	NO: _____
10.	For women: Are you pregnant or is there a chance you could become pregnant in the next month, or are you breast feeding?	YES: _____	NO: _____

Patient Signature: _____ **DATE:** _____

Form Reviewed By: _____

Vaccine Administered By: _____

MERCK-Vaqta: Hepatitis A Vaccine

Lot #:R009799 Exp 06-02-2019

NDC: 0006-4096-02