MyCare Health Center Registration and Declaration of Income for Vaccinations

Last Name	First Name		Middle Initial
Street Address	City	State	Zip Code
Social Security Number	Date of Birth	Age	Gender ❑ Male ❑ Female
Home Telephone	Other Telephone (please specify, cell, work or other)		

Race (please check the boxes below):

❑ Asian	❑ American Indian/Alaska Native
❑ Native Hawaiian	❑ White
❑ Other Pacific Islander	❑ More than one race
❑ Black/ African American	❑ Other: _____

Ethnicity (Circle one):	Non-Hispanic	Hispanic

Emergency Contact Name: _____

Phone Number: _____

Is the patient a minor?		If yes, parent's first & last name
❑ Yes	❑ No	

Please present insurance card and identification card.

Insurance Subscriber's Name:

_____

Date of Birth: _____

Marital Status (circle one):

Married Divorced Single

Veteran Status (circle one):

Active Retired N/A

Referred by/How did you hear about us?

_____

1. Do you currently have Medical Insurance coverage through any source? Yes or NO

*Patients having no insurance coverage or insurance that may not cover the influenza vaccine may complete the Income Declaration below. The information will only be used to determine eligibility for free immunizations. This Income Declaration is valid only for the date it is completed. Eligibility for no cost immunization does not guarantee enrollment in the MyCare Health Center Sliding Fee Discount Program. Please see any MyCare staff member if you are interested in information about the Sliding Fee Discount Program for all your healthcare needs.

2. What is your household (circle one) WEEKLY, MONTHLY, or ANNUAL Income? Income shall include all cash, check or electronic sources of money used for the maintenance of your household.

   _____

3. How many related family members are living together within your single household?

   _____

4. Would you like assistance applying for health insurance coverage? Yes or NO

I, _____, do state that the above information is true and complete to the best of my ability. I understand that any intentional errors or omissions may result in my receiving a bill for charges discounted in error.

I, the undersigned, am providing this consent form to MCHC (MyCare Health Center) to receive a flu vaccination. I, the undersigned, understand that by signing this consent, I waive any other preventive treatments/screenings offered by MCHC. I give MCHC permission to bill my insurance for the influenza vaccination. I release MCHC, its employees, representatives, and agents from any liability for administering the influenza vaccine. I agree to indemnify, defend, and hold MCHC harmless from any claim. I accept responsibility for seeking medical attention in accordance with the MCHC information sheet that I have received.

_____ _____

Patient/ Parent (if patient is a minor) Signature Today's Date

FOR MYCARE USE ONLY

Interviewed By: _____ Date: _____

Reviewed By: _____ Date: _____

Uploaded to MCIR By: _____ Date: _____