

**MIDLAND COUNTY HEALTH DEPARTMENT
CONFIDENTIAL CLIENT INFORMATION**

It is your responsibility to check with your health insurance company regarding coverage of specific vaccines. You can refer to our website for a list of insurance companies that we participate with. Payment is due at the time of service. We accept cash, check, Visa, MasterCard and Discover. You will be provided with a detailed receipt at the time of service for your insurance company or personal record. Most HSA accounts are not accepted.

Name: _____ DOB: _____ Age: _____ Client ID: _____

Gender: _____ SS# _____ Last Name at Birth _____

Address: _____ Home Phone: () _____

Do you have an E-Mail Address? _____ Cell Phone: () _____

What is your Ethnicity? Circle one: Hispanic, Non-Hispanic

What is your Race? Circle one: White, American Indian, African American, Alaskan Native, Asian, Native Hawaiian, or Pacific Islander

What is your preferred language? _____

Change of Address: _____
I have read and verify that the above address is correct. Client's Initials _____

Check one of the following

- _____ **Enrolled in Medicaid**
- _____ **Enrolled in Medicare**
- _____ **No health insurance**
- _____ **Health Insurance with immunization coverage (you may be responsible for the cost of the vaccines/admin. fees at the time of service. You will be given a receipt to submit to your insurance carrier).**
- _____ **Health insurance but immunizations not covered**
- _____ **American Indian or Alaskan Native**

If Employer Is Paying, Provide Employer's Name _____

I verify that the above information is accurate

Client, Custodial Parent or Guardian Name (Please Print)

Client, Custodial Parent or Guardian Signature (Today's Date)

Clerks Initials