CABARRUS HEALTH ALLIANCE
at NC Research Campus

Cabarrus Health Alliance
Registration Form
For _____

Patient Name _____ ____________ ____ ____ _____
(Please Print) (Last) (First) (MI) (Date of Birth) (Age) (Sex) (Marital Status)

_____
(Address) (City) (State) (Zip) (County)

_____ _____-_____-_____ Race: (Circle One) White Black Indian Pacific Islander Other_____
(Home Phone) (Social Security #) Ethnicity: (Circle One) Hispanic **YES NO**

I authorize to pay for the (check appropriate boxes):

☐ Hepatitis B vaccine (3 doses) ☐ TB Skin Test ☐ Td/Tdap
☐ Hepatitis B vaccine (2 doses) ☐ QuantiFeron Gold Blood TB Test ☐ Specify Other _____
☐ Hepatitis B Titer

Employee Name _____

Authorized by: _____ Date _____

Authorization good until: _____ **(Please issue separate form for each visit/dose required.)**

PLEASE ANSWER THE FOLLOWING:

1. **Allergic to yeast or yeast products?** **YES NO**
2. **Pregnant or breast-feeding?** **YES NO**
3. **Have fever or active infection TODAY?** **YES NO**
4. **Allergic to Latex?** **YES NO**
5. **Have had a severe reaction to previous vaccines?** **YES NO**
6. **Have you ever had a positive reaction to a TB skin test?** **YES NO** **If yes, when _____**
7. **Have you ever taken TB medications?** **YES NO**

CONSENT FOR HEPATITIS B

I understand I will receive the hepatitis B vaccination in three doses over a six-month period or in 2 doses second dose after 30 days of the first. I have read the Vaccine Information Statement and have had my questions answered. I believe I understand the risks and benefits of the hepatitis B vaccine and request that the vaccine be given to me.

CONSENT FOR TUBERCULOSIS (TB) SKIN TEST

I give my consent to receive a Tuberculosis (TB) skin test done by a nurse from the Cabarrus Health Alliance.

CONSENT FOR TUBERCULOSIS BLOOD TEST (QuantiFeron)

I give my consent to have my blood drawn by a nurse from Cabarrus Health Alliance for the purpose of Tuberculosis testing and sent to LabCorp for processing.

CONSENT FOR Td/Tdap

I have read the Vaccine Information Statement about the Td/Tdap vaccine and have had my questions answered. I believe I understand the risks and benefits of this vaccine and request that the vaccine be given to me.

I authorize the release of any medical information necessary to _____ to process this claim. I authorize that TB test, titer results and any vaccines given may be sent to _____. If payment is denied by _____ I agree to be personally and fully responsible for payment.

I have been provided access to the Cabarrus Health Alliance Notice of Privacy Practices.

X_____
Signature of Employee Date

FOR OFFICE USE ONLY **Privacy info given? YES/ NO**