DATE: _____ CLIENT DEMOGRAPHIC INFORMATION: (Please print)

Client Name (person receiving services)**:** Last_____First_____MI_____

Date of Birth*:* _____/_____/_____ *(mm/dd/yyyy)* **Gender** *(circle)***:** Male Female Other

Mailing Address: _____ **Apt. #:** _____

City: _____**County:** _____ **State:** _____ **Zip Code:** _____

Phone: (_____**)** _____**-**_____ □ No Texts Please **Email:**_____ □ No Emails Please

Race: □ White □ American Indian or Alaska Native □ Asian □ Black/African-American
□ Native Hawaiian/Pacific Islander □ Other □ Declined

Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino □ Declined

Parent/Guardian Name *(if patient is under 18 years of age):* _____
Date of Birth*:* _____/_____/_____

Relationship to client: □ Mother □ Father □ Legal guardian □*Other (specify): _____
*** must provide 3rd party authorization**

Emergency Contact: _____**Phone:** _____**Relationship:**_____

INSURANCE INFORMATION: Please CHECK the box that best describes client's insurance coverage

□ No Insurance
□ Has health insurance that covers vaccines
□ Employer/Agency Paid (Name):_____
□ Healthy Montana Kids *Plus* (Medicaid)
□ Healthy Montana Kids (CHIP)
□ Self-Pay (has insurance but does not want to use it)
□ Has health insurance that ***Does Not*** pay for vaccines (not including high deductible or co-pays)
□ Insurance for ***Adults*** that covers only certain vaccines or is capped at a certain amount
□ Insurance for ***Adolescents*** that covers or partially covers vaccines, but the co-pay or deductible is too expensive for family to pay

If client is NOT the insurance subscriber, please complete the information below:

Subscriber's Name:_____ DOB:_____ Relationship to client: _____

Subscriber's Address (if different than client's): _____

Does client have a Secondary Insurance: □ Yes □ No If yes, please give card to front desk person and complete items below:

Subscriber's Name:_____ DOB:_____ Relationship to client: _____

Subscriber's Address (if different than client's): _____