Desired Administration Day ◯ Please select your store ◯

ISLAND DRUG Service Excellence Delivered Locally

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360.675.6688 P
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www.islanddrug.com
wecare@islanddrug.com

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Clinton, WA 98236
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wecare.south@islanddrug.com

HPV Vaccine ("Gardasil") Administration Form

Welcome to Island Drug! Please complete this form so that we can ensure that our pharmacy file is accurate and up to date. Thanks!

_____ _____/_____/_____

First Name M.I. Last Name ☐M or ☐F Date of Birth (MM/DD/YYYY)

_____ _____

Street Address (PO Box acceptable if given with physical address) City

_____ _____ (____)_____ _____

State Zip Code Home Phone **Email Address**

ALLERGIES: ☐No Known Allergies ☐**EGGS** ☐Penicillin ☐Sulfa ☐Neomycin ☐Gelatin ☐Other:_____

MEDICAL CONDITIONS: ☐No Known Medical Conditions ☐High Blood Pressure ☐Diabetes (Type I) ☐Diabetes (Type II) ☐High Cholesterol ☐Asthma ☐Arthritis ☐Depression ☐Pregnancy (Due: _____) ☐Other:_____

Did you receive a flu shot last year? ☐YES ☐ NO **| Primary Care Doctor or Clinic:**_____

Do you get prescriptions filled by Island Drug?☐YES ☐ NO **| Do You Have GROUP HEALTH or STERLING?** ☐YES ☐ NO

I have received the current HPV vaccine information sheet, and/or have had explained to me the information on the sheet about the vaccine. I have had the chance to ask questions and they were answered to my satisfaction. I believe I understand the benefits/risk of the vaccine and ask that it is given to me or the person named above for whom I am authorized to make this request. I also received the Notice of Privacy Practices.

_____ _____

Signature **Date (MM/DD/YYYY)**

INSURANCE / MEDICARE INFORMATION

Medicare # on Card (including letter) _____**Social Security #**_____

Pharmacy instructions ** we can bill Medicare Part B, this will show on the card (unless it is dated before 1988, all cards prior to this date are fine as long as they don't have another insurance.) If Part B does not show on the card and it is dated 1989 to present then the patient must prove they have Part B (i.e. bring in a letter from Medicare stating that Part B eligibility/charge them cash then reimburse when they show proof of Part B)

GROUP HEALTH Member# _____ **Other Insurance ID#** _____

I am aware of the pharmacy's policy that billing my insurance/Medicare on my behalf is a courtesy provided by them and that I am responsible for any deductible or co-insurance amounts. I understand that Medicare may pay part of the amount billed by the pharmacy or part of Medicare'' allowable amount whichever is less and that I am responsible for the remaining amount. Also, I understand that if any of my claims are rejected by my insurance/Medicare, I will pay the pharmacy for the full amount of the claim. I recognize my obligation to forward payment to the pharmacy for any payment received by me due to them.

INSURANCE LIFE-TIME AUTHORIZATION:

I request payment under the medical insurance program be made to me or the provider names above on any bills for service. I authorize the above named provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in the place of the original.

Patient's Signature: _____

If for some reason, the patient is mentally or physically unable to sign this card, the signature of a relative, friend, legal guardian, representative payee, or the representative of any institution providing care is acceptable. The name of the patient should be shown on the signature line followed by "BY", and the signature and address of the individual signing for the patient. The mental or physical problem, which does not allow the patient to sign, and the relationship of the person signing on their behalf, must also be indicated on this card. A physician or supplier's office cannot sign on behalf of a patient except under extraordinary circumstances. Please contact the Medicare Office if you need further details.

Office use:

DATE OF VACCINATION:_____ Signature of Administrator:_____

MNF:_____LOT#_____EXP DATE:_____

SITE OF INJECTION: R OR L Deltoid

Visit us online at ***www.islanddrug.com***

Signature:

Email: