Whitman County Public Health

310 N Main St, Ste 108
Colfax, WA 99111

1205 SE Pro Mall Blvd, Ste 203
Pullman, WA 99163

INTAKE FORM

Today's Date _____ **Location** ☐ Colfax ☐ Pullman ☐ Other _____

Client Name _____ **Phone** _____
(Last) (First) (Middle)

Client Address _____
(Street/P.O. Box) (City) (State) (ZIP)

Date of Birth _____ **Age** _____ **Sex** ☐ Male ☐ Female ☐ Transgendered

Race (Optional) ☐ Caucasian ☐ Native American ☐ Asian/Pacific ☐ African American ☐ Hispanic ☐ Other

My signature authorizes immunization and/or TB skin testing services to be provided by a Whitman County Public Health Nurse.
Authorized signature (Client/Guardian) _____

Complete if requesting sliding fee scale

Number in Household _____ Gross Household Income _____ ☐ Monthly ☐ Bi-monthly ☐ Annually

PLEASE DO NOT WRITE BELOW THIS LINE

90471	Vaccine Administration Fee x1 vax	20.00
90472	Vaccine Administration Fee x2+ vax	30.00
86580	TB Test, 1 Step Office Visit	45.00
86580	TB Test, 2 Step Office Visit	55.00

(32.01) Immunization Service - State Child Vaccines

90702-SL	DT	-
90700-SL	DTaP	-
90723-SL	DTaP/HBV/IPV *(Pediarix)*	-
90696-SL	DTaP/IPV *(Kinrix/Quadracel)*	-
90698-SL	DTap/HIB/IPV *(Pentacel)*	-
90633-SL	Ped Hep A	-
90744-SL	Hep B	-
90648-SL	HIB prp-t	-
90651-SL	Gardasil *(HPV)*	-
90657-SL	Influenza Injection (6-35 months)	-
90658-SL	Influenza Injection (3-18 years)	-
90672-SL	Influenza Flumist Nasal Spray (2-18 years)	-
90713-SL	IPV	-
90707-SL	MMR	-
90710-SL	MMRV	-
90669-SL	PCV-13	-
90680-SL	Rotavirus	-
90718-SL	Tetanus/TD	-
90715-SL	Tdap	-
90716-SL	Varicella	-
90734-SL	Meningococcal *(Menactra)*	-

Action (initial)

Diagnostic Code (Circle)

Z23	Encounter for Immunization
Z11.1	Encounter for TB Screening

(32) Immunization Service - Adult Private

90632	Hep A Adult (19+ years)	45.00
90739	Hep B/Hepisav (19+ years)	125.00
90658	Influenza Injection	25.00
90718	Tdap	48.00
90707	MMR	80.00

VFC Eligible?
- ☐ Medicaid/Medicaid Managed Care
- ☐ Uninsured
- ☐ American Indian/Alaskan Native
- ☐ Underinsured
- ☐ CHIP
- ☐ Private Insurance

Amount Due $_____
Sliding Fee Scale A B C D

Payment
- ☐ Check Check # _____
- ☐ Cash Receipt # _____
- ☐ Credit/Debit Order # _____
- ☐ Bill to _____

LPN: Deanna ☐ ☐

Billed _____ **Invoice #** _____ **Date** _____ **WAIIS** _____ **Date** _____
Client Management _____ **Date** _____