## CENTRAL UTAH PUBLIC HEALTH DEPARTMENT-CLIENT PPD CLIENT ENCOUNTER

BIRTH DATE/								Visit Date//			
Patient'	s Name _										
Age	Last Race Sex M					M F		First Home Phone	Middle 		
Mailing	Address_										
Street/Apartment #/P. O. Box								City	State	Zip	
Mother's Maiden Name:Name of Insurance									n: d		
								#:	Group _		
The no descri	otice of Pr bed. CUP	ivacy Pra HD is red n a copy	ctices tell uired to i of CUPI	s you ho inform yo HDS's No	w CUPHE u of our p	may use rivacy pra	e or disc actices f	or the inform	ril 14, 2003 tion about you. Not all sit action we collect and keep ad a chance to ask que	about you. I	
treatme Public I unders	ent that au Health Dep stand if my	thorized partment insurance	persons to bill my ce provide	of the Ce Medicaid er fails to	entral Utal I, Medicar cover the	h Public re and/or cost of the	Health [ Insurand his servi	Department ce. ce, I will be r	camination, screenings, to may prescribe. I authoring esponsible for the payme	ze the Central Uta	
Signature Date								Relationship to Patient			
			***	*****	****FOR	OFFIC	E USE	ONLY***	****		
CPT	ICD10	NAME	TIME	LOT	DOSE	ROUTE	SITE	PRICE	North Councits	South Sanpete Wayne Sevier	
86580		PPD			0.1CC	ID	0	\$15	North Sanpete Juab		
00000	220.1	ITD			0.100	ID		\$15	Piute		
PPD F	PPD READING RESULTS:								East Millard	West Millard	
DATE	READ										
521	Nursing Home							Allergies:			
522	Contact										
523	Other							Comments:			
533											
534 Correctional Facitlity							Nu	Nurse/Provider:			
435	•							PAYMENT SECTION			
536								Total Charge:			
537								Amount Received:			
538								Total Owing:			
539								CASH		CREDIT CARD CONTRACT	
540 Substance Abuse											
572 Chest X-Ray								BILL ORGANIZATION:ORG. ADDRESS:			
573	Follow						OF	KG. ADDRES	0		
574 Final Visit CHECK									USIIS:		
Employee Signature:									COMPUTER:		
_mploy	ree Signat	ure:						ATIMEINT.			