General Patient Registration

Please print clearly and a valid government photo identification is required
All information requested is necessary
This form is kept confidential in our office and is not released to anyone.

HEALTHY TRAVELER

Information About You

A W _____

TODAY'S DATE _____/_____/_____ **CHECK ONE: NEW patient** _____ **RETURNING PATIENT** _____ **Last visit?** _____/_____/____

LAST Name _____ **FIRST** Name _____ **MIDDLE** Name _____

STREET Address _____ **Birthdate:** Month _____ Day_____ Year _____

City _____ State _____ Zip Code _____ Male ___ Female____ Age Today _____

Mobile/Cellular _____/_____ Accept Text Messages? Yes___ No___ Home/Office _____/_____

Your email address: _____ Last 4 Digits of your Social Security _____

Status: Single __ Married __ Minor under 18 ___ Employer _____ Occupation_____

REQUIRED: Emergency Contact Name _____ Phone_____/_____ Relationship _____

Under 18 years old, your parent or legal guardian is _____ Telephone _____/_____

HELP US: How did you learn about our clinic? _____

MEDICAL SERVICE(S) YOU ARE REQUESTING _____

_____

Medical History

PLEASE ANSWER THE FOLLOWING:

- In the past 30 DAYS have you had vaccinations for chickenpox (varicella), yellow fever, measles/mumps/rubella (MMR) or shingles (Zostavax)? **YES** ❑ No ❑
- Do you live (or work closely) with anyone who has immune disorder from AIDS, cancer chemotherapy, organ transplant...etc? **YES** ❑ No ❑
- Do you live (or work closely) with anyone who is pregnant and not immune to chickenpox (Varicella)? **YES** ❑ No ❑
- Have you had a blood transfusion or gamma globulin injection in the past 6 months? **YES** ❑ No ❑
- Are you now taking any steroids. prednisone or cortisone (tablet or injection)? **YES** ❑ No ❑
- Could you now be pregnant or might you become pregnant in the next 30 DAYS? **YES** ❑ No ❑
- Do you have AIDS, any other immune disorder, leukemia or cancer? **YES** ❑ No ❑
- Are you allergic to aminoglycoside antibiotics--eg. gentamicin etc.? **YES** ❑ No ❑
- Are you allergic to gelatin? **YES** ❑ No ❑

Your Consent and Agreement

I authorize Healthy Traveler® Clinic to administer the medical service(s) requested above.

- Minors under 18 years of age must be accompanied by a parent or legal guardian.
- I understand the Healthy Traveler Clinic® is NOT a member of any insurance plan or network and the clinic does NOT accept insurance or any type of billing. All insurance claims and processing is between my insurance company and the insured.
- For Medicare eligible patients, I understand and acknowledge that Part B Medicare **DOES NOT** cover the cost for immunizations and vaccinations, therefore, the cost of immunization and vaccination will be an out of pocket expense and you have elected to **OPT-OUT** of Medicare for a Private For Pay Service with Healthy Traveler Clinic

Print Your Full Name _____

Your Signature _____ Today's Date _____/_____/_____

For Clinic Only:_____

Vaccine Administration Record

Last Name _____ First Name _____ DOB M____ D____ Y_____

R D	rd ld G ralt lalt	DOSE 1	rd ld G ralt lalt	DOSE 2	rd ld G ralt lalt	Hep B DOSE 4
H-A						
R D	rd ld G ralt lalt	DOSE 1	rd ld G ralt lalt	DOSE 2	rd ld G ralt lalt	DOSE 3
H-B						
R D	rd ld G ralt lalt					
TD TDP						
R D	rd ld G ralt lalt					
TYP						
R D	rd ld G ralt lalt					
POL						
R D	rd ld G ralt lalt		rd ld G ralt lalt	DOSE 2		
MMR						
R D	rd ld G ralt lalt					
YF						
R D	rd ld G ralt lalt	DOSE 1	rd ld G ralt lalt	DOSE 2	rd ld G ralt lalt	DOSE 3
JE						
R D	rd ld G ralt lalt	DOSE 1	rd ld G ralt lalt	DOSE 2	rd ld G ralt lalt	DOSE 3
RAB						
R D	rd ld G ralt lalt					
MEN						
R D	rd ld G ralt lalt	DOSE 1	rd ld G ralt lalt	DOSE 2		
VAR						
R D	rd ld G ralt lalt		rd ld G ralt lalt		rd ld G ralt lalt	
R D	rd ld G ralt lalt		rd ld G ralt lalt		rd ld G ralt lalt	