# International Travel Paperwork

**Personal Information**

Date:____________________

Patient's Name:________________________________________DOB:________________________

Address: ________________________________________________SSN:_______________

________________________________________________Home#:_________________

________________________________________________

Email Address_________________________________________________

Marital Status: Single Married Separated Widowed Divorced

Employer:___________________________________________Work #__________________________

Occupation:_________________________________________________________

Emergency Contact:___________________________________________________

Emergency Contact #__________________________________________________

Relationship to Patient:______________________________________________

Referred by:____________________________________

PCP/Referring Doctors Phone Number:__________________________________

Complete the following only if the patient is a minor

Responsible Party Name_______________________________Relationship________________________

Responsible Party Home#__________________________Work or Cell___________________________

..........................................................................................................................................................

**Insurance Information: Please allow us to scan in your insurance Card**

***Primary*** Insurance Company Name______________________________________________

Policy Holder Name_______________________________DOB___/___/___SS#__________________

ID Number_____________________________________Group Number__________________________

Patient relationship to the policy holder/insured: ( )Self ( ) Spouse ( ) Child ( ) Other

***Secondary*** Insurance Company Name______________________________________________

Policy Holder Name_______________________________DOB___/___/___

ID Number_____________________________________Group Number__________________________

*In case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect this amount or any future outstanding account balances.

## HIPAA Consent &Financial Policy

Patient Name:___________________________________DOB:_______/______/______

**HIPAA:** The practice provides this information to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Our notice of privacy practices provides information about how we may use and disclose protected health information about you. The notice contains a patients' rights section describing your rights under the law. By signing below, the patient understands:

*Protected health information may be disclosed or used for treatment, payment, or health care operations.

*The patient has the right to review and request a copy before signing. (Please ask our staff if you wish to review or obtain a copy of our privacy practices.)

*The patient has the right to restrict the uses of their information, but the practice does not have to agree to those restrictions.

*The practice may condition receipt of treatment upon the execution of this consent.

*The patient may revoke this consent in writing at any time and all future disclosures will then cease.

**Release of Information:**

Besides myself, I authorize this practice to discuss personal medical information with the following person(s):_____________________________and/or____________________________

Messages may be left: (regarding appointments and call back information only)

Check all that are authorized:___Home Answering Machine____Email__Cell__Work

***Insurance and Assignment of Benefits:***

I hereby authorize this practice and its providers to apply for benefits on my behalf for covered services rendered. I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier (or in the case of Medicare Part B benefits, to the Social Security Administration and health care financing administration). A copy of the authorization may be used in place of the original. This authorization may be revoked by either me or my insurance carrier at any time in writing.

I hereby authorize payment to of all medical insurance benefits to be paid directly to this practice and its providers for services rendered. I understand and agree that I am financially responsible for charges not paid by my insurance company. I understand that in certain instances my insurance may decide that medical services are not medically necessary and that payment may be denied for these services. I agree to be personally and fully responsible for payment of any denied charges. If I have Medicare, I understand that I may be asked to sign an advanced notice/waiver for certain services or procedures.

I hereby certify that the information I have provided is correct. I hereby certify that I have read, understand, and agree with the above HIPAA and financial policies. I further agree to pay bank charges for insufficient funds, finance charges and/or collection fees assessed to my account for any overdue balances.

We are able to accept insurance for Travel visits. We will bill all charges to your insurance company at your request. If you have a copayment at the time of services that will be collected. Please understand that not all vaccines are covered under your plan. We will initially ask for payment from the insurance company. The vaccines may be rejected and the cost may be rolled back to you.

Patient Signature______________________________________Date_____/_____/_____

## Infectious Diseases & Travel Medicine Consultants

### Traveler's health Questionnaire

Patient Name:______________________________ DOB:________________

- Do you have a heart problem? Y N
- Do you have a cardiac arrhythmia? Y N
- Do you have any eye conditions such as glaucoma? Y N
- Do you have high blood pressure or take high blood Pressure medication? Y N
- Do you have bleeding problems, take anticoagulants Aspirin or aspirin therapy? Y N
- Do you have a history of depression of psychiatric Disorder? Y N
- Do you experience nightmare or insomnia? Y N
- Do you have lung disease/asthma, chronic bronchitis Shortness of breath? Y N
- Do you, any person you live with, or any person in Your care take cortisone, prednisone steroids, Chemotherapy, (anti-cancer drugs), or radiation Y N
- Do you have diabetes? Y N
  If yes, do you take insulin? Y N
- Do you have stomach/bowel conditions such as Frequent diarrhea or constipation? Y N
- Are you prone to motion sickness? Y N
- Have you ever fainted from an injection or a blood Draw? Y N
- Do you have any skin diseases or psoriasis? Y N
- Are you allergic to bee stings? Y N
- Do you have any Egg allergies? Y N
- Do you have an active nerve disorder? Y N
- Do you have a history of Guilian-Barre Syndrome Y N
- Are you presently experiencing any respiratory Infections, or other acute illnesses or infections? Y N
- Do you have tuberculosis or tested positive for TB Y N
- Do you, any person you live with, any person in your Care have cancer, leukemia, AIDS, or any other immune System problem? Y N
- During the past three months, have you received a Transfusion of blood or plasma or been given a Medicine call immune globulin? Y N

**Medication Allergies:**______________________________________________

**Current Medications:**______________________________________________

______________________________________________

## Infectious Diseases & Travel Medicine Consultants

Patient Name:________________________________________DOB:____________________

Questions for Women:

- Are you pregnant? Y N
- Do you plan to become pregnant in the next 3 mo.? Y N
- Are you breastfeeding now? Y N
- Do you have problems with vaginitis? Y N

Please list the countries you are traveling to (In Order) Approximate Length in each country:

___________________________________________ ________________________________

___________________________________________ ________________________________

Departure Date:_________________________ Return Date:______________________

Reason for Travel: ___Tourist ___Business ___Student ___Other

Accommodations: ___Hotel ___Youth Hostel ___Family Home ___Cruise ___Camping

Do you plan to visit tourist areas or major cities? Y N

Do you plan to visit rural areas? Y N

Do you plan to visit rural areas during evening or nighttime hours? Y N

Do you plan to go hiking or backpacking? Y N

Do you plan to go bicycling? Y N

Do you plan to go swimming? Y N

If yes: ___Chlorinated Pool ___Fresh water or stream ___Ocean

Do you plan to travel or climb to high altitudes? Y N

If yes: To what altitude:__________________

Do you plan to scuba dive? Y N

If yes are you certified? Y N

When is air travel scheduled after last dive? _____________________

**Preferred Pharmacy:**______________________________________________________

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**Internal Use**

Previous Vaccinations: ________________________________________________________________

Vaccinations Recommended:

____TDAP ___Typhoid ___Hep A ___Hep B ___Twinrix ___Japenese Encep.

___Meningitis ___IPV ___Yellow Fever ___Flu ___MMR ___Rabies

Traveler's Diarrhea Script ______________________________________________________________

______________________________________________________________

Malaria Medication_________________________________________________________________

_________________________________________________________________