Traveler's Health and Immunization Center
7900 N. Milwaukee Ave., Suite 231
Niles, IL 60714
(847) 663-9500
www.travelmed.net
Traveler's Health & Immunization Center

PATIENT REGISTRATION

Name ____
Last First Middle

Address____
Street

______________________________ __________
City State Zip

Telephone (H) _______________(W) ______________ (C)_______________

Date of Birth _________________ Driver's License # ___________________
MM/DD/YYYY

Emergency Contact ____
Name Phone

Primary Care Physician ____
Name Phone

Email Address (for reminders) ____________________________________

How did you hear about our clinic? (Please circle)
Your physician Hospital referral Friend Employer
Internet Other_________________

If you were referred by your employer, please provide the following information:

____
Company Name Contact Person Phone

PAYMENT POLICY

I acknowledge that Traveler's Health and Immunization Center, S.C. requires full payment at the time of service. We will provide you with an itemized invoice that you may submit to your insurance company for reimbursement (if eligible). In the event that reimbursement is sent directly to us, we will forward that reimbursement to you along with a copy of the explanation of benefits (EOB).

Signature ______________________________ Date ___________________
Patient or guardian of minor patient

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Consent to the Use and Disclosure of Protected Health Information for <u>Treatment, Payment and/or Healthcare Operations</u>

I understand that Traveler's Health and Immunization Center, S.C. originates and maintains protected health information for the purpose of treatment, payment and healthcare operations.

I understand that since Traveler's Health and Immunization Center, S.C. has the right to change their Privacy Practice in accordance with the law, the terms contained in the Notice of Privacy Practices ("Notice") may change as well. Traveler's Health and Immunization Center, S.C. will provide a copy of the most updated Notice in the office. They are also required to provide me a copy of the Notice on my first visit as required by law. I will also be provided a copy of the Notice upon request.

As more fully explained in the Notice, you have the right to request restrictions on how Traveler's Health and Immunization Center, S.C. can use or disclose your protected health information for treatment, payment and/or healthcare operations. Traveler's Health and Immunization Center, S.C. is not required to agree to your request. If your request is approved, Traveler's Health and Immunization Center, S.C. is required to comply with your restriction unless the information is needed for emergency treatment. Restrictions should be noted on the form attached. These restrictions will stay in effect until otherwise terminated. Any other practitioner who provides coverage for Traveler's Health and Immunization Center, S.C. is required to use or disclose your protected health information as stated in the notice.

I understand that I have the right to revoke this consent provided I do so in writing, except to the extent that Traveler's Health and Immunization Center, S.C. has already used or disclosed the information relied upon by this consent.

I acknowledge receipt of Traveler's Health and Immunization Center, S.C. Notice of Privacy Practices. I understand this document provides additional information about the use and disclosure of my protected health information.

____________________________________ ____________________

Signature of patient or legal guardian Date

____________________________________ ____________________

Name of patient or legal guardian Relationship to patient

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TRAVEL INFORMATION AND HEALTH HISTORY FORM

Name ____________________________________ Date of birth __________________

Date of departure __________________________ Length of stay _________________

ITINERARY (in exact order)

DESTINATION (Country/Cities)	DURATION OF STAY

Nature of travel (check all that may apply):

Business Pleasure Missionary Medical Student

Urban Rural Tour Guided: yes no

If traveling for business: who is your employer? ______________________________

Activities during travel (check all that may apply):

Trekking Camping Mountain climbing
Safari Scuba diving Medical/dental work
Motor vehicle use Sunbathing Swimming

Accommodations (check all that may apply):

Hotel/resort Cruise ship Tented camp
Wilderness Private home

MEDICAL HISTORY

♦Do you have or have you ever had? (check all that may apply):

- € Diabetes
- € High Blood Pressure
- € Irregular Heart Rhythm (arrhythmia)
- € Cancer (specify type, last chemotherapy and radiation treatment) ______________________________
- € Immune Deficiency (e.g. HIV/AIDS) (specify) ______________________________
- € Thymus gland disorder
- € Myasthenia Gravis
- € Guillain-Barre Syndrome
- € Crohn's Disease
- € Ulcerative Colitis
- € Rheumatoid Arthritis
- € Systemic Lupus
- € Tuberculosis (disease or positive skin test)
- € Eczema
- € Seizure Disorder
- € Depression or Anxiety Disorder
- € Any other mental illness for which you have received treatment
- € Reaction to a Vaccine (specify) ______________________________
- € Travel-Related Illness (specify) ______________________________
- € A bad reaction to a medication prescribed for malaria? (specify) ______________________________
- € Other (specify) ______________________________

♦Current medications: ______________________________

♦Are you taking any blood thinners (e.g. coumadin) Yes No
If YES, which one(s)? ______________________________

♦Are you taking or have you taken any immunosuppressive medications?
(e.g. prednisone, Remicade, Enbrel) Yes No
If YES, which one(s) and when? ______________________________

♦Are you **ALLERGIC** to any medications? Yes No
If YES, which one(s)? ______________________________

♦Check if you are **ALLERGIC** to: Eggs Yeast Thimerosal (mercury)

- € insect bites
- € Chicken
- € Formaldehyde
- € Neomycin

€ Gelatin

€ Latex

♦ **FOR WOMEN:** Are you pregnant? Yes No
Do you plan to become pregnant in the next 6 months? Yes No

IMMUNIZATION HISTORY

VACCINE	WHEN RECEIVED		
Hepatitis A			
Hepatitis B			
Twinrix (combined Hepatitis A + B)			
Yellow Fever			
Typhoid (injection)			
Typhoid (oral)			
Polio (injection)			
Polio (oral)			
Meningococcal (meningitis)			
Tetanus			
Japanese Encephalitis			
Rabies			
Varicella (Chickenpox)			
Measles			
Mumps			
Rubella (German Measles)			
Influenza (Flu)			
Pneumovax (Pneumonia)			

I certify to the best of my knowledge all information provided on this form is complete and accurate as of today's date.

x
____Date____________

Signature of patient/legally responsible party

Relationship to patient ______________________________

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Requests for Limitations and Restrictions of Protected Health Information:

PLEASE NOTE: Traveler's Health and Immunization Center, S.C. is not required to agree to your request. Please refer to our **Notice of Privacy Practices** for more information regarding such requests.

Patient Name: ________________________________ Date of Birth: _____________

Address: ____

City: ___________________________ State: _______________ Zip: _____________

PLEASE INITIAL ONE OF THE FOLLOWING OPTIONS:

_________ I do not request any restrictions to my Protected Health Information.

_________ I would like to restrict my Protected Health Information as follows:

____

____

____

_____________________________________ _________________________
Name of patient or legal guardian Date

____
Signature of patient or legal guardian

____
Relationship to patient