

PASSPORT HEALTH PATIENT INFORMATION/CONSENT

Please Print

OFFICE USE	
<input type="checkbox"/>	Client entered
<input type="checkbox"/>	Dr. entered
<input type="checkbox"/>	Records Sent
<input type="checkbox"/>	YF
CLIENT INFORMATION REVIEWED BY R.N.	
_____ R.N. INITIALS	

NAME: _____
Last First Middle Initial

ADDRESS: _____
Street Apartment/Space #
City State Zip Code

BIRTHDATE: _____ AGE: _____ MALE FEMALE

Cellphone Number: _____ HOME PHONE: (_____) _____
AREA CODE

EMPLOYER: _____ WORK PHONE: (_____) _____
AREA CODE

OCCUPATION: _____ EMAIL ADDRESS: _____

HOW DID YOU HEAR ABOUT PASSPORT HEALTH: Phonebook Doctor DEX Online Expedia
 passporthealthaz.com passporthealthusa.com Family or Friend Other _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____
Do you want us to send your primary care physician a copy of your immunization record? Yes No

ARE YOU GOING OUT OF THE COUNTRY? NO YES

* **WHERE? List each country:** _____

Length of stay: _____ Date Leaving: _____ Date Returning: _____

Purpose of Travel/Visit: _____

Chronic illnesses: _____

Do you have eczema or other chronic dermatitis? yes no If yes, Type: _____

Do you have or have you ever had anxiety &/or depression, or any other mental illness? yes no If yes, Type: _____

Have you ever had a seizure or convulsion? yes no

Have you had chickenpox? yes no

Allergies to medications. no YES If yes, which medications: _____

Allergic to eggs, feathers, yeast, thimerosal, quinine, formaldehyde or insect/bee stings? no yes. If yes, _____

Do you have high blood pressure? yes no If yes, what medication(s) are you taking: _____

Other current medications (including contraceptives): _____

Are you receiving steroid medications such as cortisone or prednisone? yes no If yes, name: _____

Are you receiving radiation or other treatments? yes no If yes, type: _____

Are you pregnant now or is there a possibility that you might be pregnant? yes no n/a If yes, months: _____

Are you planning to become pregnant within 3 months? yes no n/a

Have you had immune globulin or a vaccine in the last 3 months? yes no

Do you have a history a thymus disorder? yes no

Have you had an allergic reaction to an immunization in the past? yes no If yes, what? _____

Have you ever had a positive TB skin test? yes no

I understand that payment for services is expected at the time of service by cash or credit card, unless there is a corporate payment contract. I understand certain information must be released to the paying entity under corporate contracts. I understand that Passport Health does not accept or file any insurance, including Medicare & that I can not file Medicare claims myself. I give permission to Passport Health to release medical information to my physician at my direction. I give my consent for immunization administration & understand that I will receive written/verbal information about each vaccine/medication & possible side effects. I understand that it is recommended that I remain in the office for at least 15 minutes following an injection. Vaccines/medications may not be exchanged or returned. Unopened travel supplies may be exchanged or returned within 10 days.

Client Signature/ Parent or Guardian if under 18: Sign & Print Name

Today's Date