

PASSPORT HEALTH PATIENT INFORMATION/CONSENT

Please complete front and back of this form. Email to contact@passporthealthatlanta.com as PDF file or print and fax back to 770-649-1678 or bring completed form to our office the day of your appointment.

NAME: _____ DATE: _____
Last First Middle Initial

ADDRESS: _____ BIRTHDATE: _____ AGE: _____
Street Apt #

City State Zip SEX: M F HOME #: () _____ - _____

If patient is under 18 please have parent or guardian fill out the following: CELL #: () _____ - _____

EMPLOYER: _____ WORK #: () _____ - _____

EMPLOYER ADDRESS: _____
Street City State Zip

OCCUPATION: _____ E-MAIL: _____

REFERRAL SOURCE: _____

EMERGENCY CONTACT: _____ PHONE # _____
Name Relationship

Do you want us to send your primary care physician a copy of your immunization record? Address Must Be Complete In Order to Properly Notify Your Physician's Office		<input type="checkbox"/> Yes <input type="checkbox"/> No
Physician's Name:		
Physician's Office Address:		
Physician's Telephone Number:		

Where are you going? (List individual countries in sequence of visit) 1) _____ 2) _____
 3) _____ 4) _____ 5) _____ 6) _____

Length of stay: _____ Departure Date: _____ Return Date: _____ Purpose: _____

Group you are traveling with: _____ Group Leader: _____

Yes No Chronic physical or mental illnesses: If yes, describe: _____

Yes No Do you have eczema or other chronic dermatitis? If yes, type _____

Yes No Known allergies to medications. List medication allergy(s): _____

Yes No Allergic to eggs, feathers, yeast, mercury, quinine, formaldehyde, latex or insect/bee stings?

Yes No Motion Sickness? If yes, what have you used in the past? _____

Yes No Do you have high blood pressure? If yes, are you on medication? Yes No List: _____

Yes No Are you receiving steroid medications such as cortisone or prednisone? If yes, type: _____

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

Yes No Are you pregnant now or is there a possibility that you might be pregnant? If yes, months: _____

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

Yes No Are you traveling against the recommendation of a physician? If yes, what is the condition? _____

Current medications (including oral contraceptives): 1) _____ 2) _____
 3) _____ 4) _____ 5) _____ 6) _____

To be effective, some vaccines require a series to be completed. Each shot of the series is priced individually. Initials _____

The above information is accurate to my best recollection. I understand that insurance may not cover travel immunization services and I am responsible for all fees associated with this visit. Passport Health is not a Medicare or HMO provider. Payment is due at the time of service by check, cash or credit card. In the unlikely event that I have a dispute with Passport Health, I hereby agree that any dispute(s) shall be settled by mediation. I understand I will receive documentation of all vaccines received and am responsible for keeping the record in a safe place and up-to-date. I give consent to the administration of the vaccines recommended by my travel health professional within the guidelines of the CDC. Active records are kept on file. Inactive records are kept on file for 3 years.

Traveler/Parent/Guardian Signature: _____

(Please complete back of form with vaccine history)

Revised: 06/29/2010

Passport Health Vaccination Questionnaire

Please indicate if you (or minor child) has had these vaccinations and approximate date. If you have original documentation of vaccinations with you, do not complete this questionnaire. We will make a copy of your original documentation for our records.

Vaccination	Yes	No	Date Completed
Hepatitis A #1 Dose			
Hepatitis A #2 Dose			
Hepatitis B #1 Dose			
Hepatitis B #2 Dose			
Hepatitis B #3 Dose			
Twinrix (Hep A & Hep B Combo) #1 Dose			
Twinrix (Hep A & Hep B Combo) #2 Dose			
Twinrix (Hep A & Hep B Combo) #3 Dose			
Twinrix (Hep A & Hep B Combo) Booster			
Immune Globulin (IG)			
Tetanus/Diphtheria (TD)			
Tetanus/Diphtheria/Pertussis (Tdap)			
Typhoid – Oral or Injection (circle)			
Polio IPOL (adult)			
Measles, Mumps, Rubella (MMR) (adult)			
Japanese Encephalitis (JE-Vax) #1 Dose			
Japanese Encephalitis (JE-Vax) #2 Dose			
Japanese Encephalitis (JE-Vax) #3 Dose			
Japanese Encephalitis (JE-Vax) Booster			
Japanese Encephalitis (Ixiaro) #1 Dose			
Japanese Encephalitis (Ixiaro) #2 Dose			
Varicella (Chicken Pox)			
Rabies IM (Pre-exposure) #1 Dose			
Rabies IM (Pre-exposure) #2 Dose			
Rabies IM (Pre-exposure) #3 Dose			
Rabies IM (Pre-exposure) Booster			
Meningococcal (Meningitis) – Menactra			
Meningococcal (Meningitis) – Menomune			
Yellow Fever			
Gardasil #1 Dose			
Gardasil #2 Dose			
Gardasil #3 Dose			
Zostavax			
PPD and Read			
Anthrax Series - #1, #2, #3, #4, #5, Booster			
Influenza – Mist or Injection (circle)			
H1N1 – Mist or Injection (circle)			
Pneumococcal (Pneumonia)			