PATIENT INFORMATION/CONSENT-IMMIGRATION PHYSICAL

LEGAL PASSPORT NAME:_____
Last First Middle

PLACE OF BIRTH:_____
(City/town/village) COUNTRY

SSN#: _____ALIEN#_____

ADDRESS:_____
Street City State Zip

BIRTHDATE:_____ AGE:_____ SEX: ☐MALE ☐FEMALE

HOME PHONE:_____CELL:_____ WORK PHONE:_____

EMPLOYER:_____EMAIL:_____

IMMIGRATION ATTORNEY:_____PHONE:_____

PRIMARY CARE PHYSICIAN :_____ PHONE:_____

Chronic physical, mental Illnesses:_____

Do you have any allergies to medication, foods, or environmental? If yes, type_____

Are you allergic to **eggs**, feathers, yeast, mercury, quinine, formaldehyde, latex or insect/bee stings?_____
If yes--What happens?_____

List vaccines you have had and dates if known including oral or nasal mist:_____

_____

Current medications (including oral contraceptives or anticoagulants):_____

_____

Do you have **eczema** or other chronic **dermatitis**? ☐ yes ☐ no If yes, type:_____
Are you receiving steroid medications such as cortisone or prednisone? ☐yes ☐no If yes, type_____
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 If yes, months_____
Have you had an **allergic reaction to an immunization** in the past? ☐yes ☐no If yes, what?_____
Do you have high blood pressure? Medication? ☐ yes ☐ no If yes, what?_____

The above information is accurate to my best recollection. I understand that insurance may not cover immigration physical services and I am responsible for all fees associated with this visit. Passport Health does not file with insurance and is not a Medicare provider. 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. Passport Health keeps active records on file. Inactive records are kept on file for 7 years. Payment is due at the time of service by check, cash or credit card.

Patient/Parent/Guardian Signature:_____ Date: _____

Remember: *Please eat before your appointment. If you have not eaten recently, let the nurse know.* *Over ->*

PASSPORT HEALTH®
First Class Medical Care For Travel Anywhere

To Allow Us to Serve you Better, Please Provide The Information Below:

How Did You Hear About Us

☐Return Client
☐Primary Care Physician
☐Passport Health Client
☐Pharmacist
☐Travel Agent
☐Company Travel Manager
☐School/College Nurse
☐CDC Site
☐Health Department
☐TV/Cable Advertisement_____
Channel/Network
☐Direct Mail _____
Promotional Code
☐Internet Ad where? _____
Website
☐Internet Search _____
Search Engine
☐Other Internet Site _____
Website
☐Radio _____
Station
☐ Other _____
Please Specify

SO THAT WE MAY SEND A THANK YOU, PLEASE TELL US MORE ABOUT THE PERSON WHO REFERED YOU

_____EMAIL_____
Salutation First Name Last Name

_____ PHONE_____
Street City State Zip

FOR OFFICE USE ONLY

_____

_____

_____

Please rate your initial experience (on a scale of 1 to 5 with 5 being the best)
Phone Professionalism: ____ Appointment Availability: ____ Access to Locations: ____

COMMENTS:_____

_____

_____

_____

_____

Thank you for your Visit to Passport Health. Your answers are strictly confidential and they will assist us in our efforts to serve you better.