PASSPORT HEALTH® OF NEW YORK STATE

First Class Medical Care for Travel Anywhere

PASSPORT HEALTH of NEW YORK STATE
PATIENT INFORMATION/CONSENT
Part I

NAME:_____
Last First Middle Initial

ADDRESS:_____
Street City State Zip

DATE TODAY:_____ BIRTHDATE:____/____/_____AGE:_____ SEX: ☐Male ☐Female
Month Date Year

HOME PHONE#:_____CELL PHONE#:_____LAST 4 OF SS#_____

HAVE YOU BEEN HERE BEFORE? ☐Yes ☐No WHEN?_____

EMPLOYER:_____ WORK PHONE: _____

REGISTER TO RECEIVE OUR FREE E-ZINE, HEALTH ALERTS, TRAVEL NEWS & HOT TRAVEL DESTINATION INFORMATION? ☐yes ☐no **EMAIL:** _____

PRIMARY CARE PHYSICIAN:_____PHONE:_____

ADDRESS/LOCATION:_____
Do you want us to send your primary care physician a copy of your immunization record? ☐yes ☐no

Where are you going? (Please List Countries in Order) Aprroximate Length of Stay in Each Country

_____ _____
_____ _____
_____ _____
_____ _____

Departure Date_____ Return Date_____

Chronic physical or mental Illnesses:_____
Do you have eczema or other chronic dermatitis? ☐yes ☐no If yes, type_____
Previous History of tendonitis/tendon rupture ☐yes ☐no
☐ No known allergies to medications. ☐ Medication allergy to:_____
List all recent vaccines you have had and dates if known including oral or nasal mist:_____
_____
Allergic to eggs, feathers, yeast, mercury, quinine, formaldehyde, latex or insect/bee stings?_____
Motion Sickness? ☐yes ☐no If yes, what have you used in the past?_____
Do you have high blood pressure? ☐yes ☐no If yes, are you on medication?_____
Current medications (including oral contraceptives or anticoagulants):_____
_____
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?_____

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 provider. Payment is due at the time of service by check, cash or credit card. 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 3 years.

☐ I have read the HIPAA Policy and Consent Form.

Traveler/Parent/Guardian Signature:_____

PLEASE CONTINUE TO THE BACK OF THIS PAGE

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Part II

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

How Did You Hear About Us

☐Return Client ☐ Friend
☐Family Member
☐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

_____

_____

_____

Would you be interested in receiving additional information regarding research studies? ☐yes☐no

Purpose of visit ☐Business ☐Leisure ☐Mission ☐Study Abroad ☐Visiting Friends/Family ☐Adoption ☐Other

Are you Traveling ☐Alone? ☐ In a Group? ☐With Your Company? ☐With Your School?

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.