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PLEASE PRINT AND COMPLETE IN FULL **TRAVEL PAPERWORK**

Date:_____

Name:_____ Nickname:_____
Last First M

Sex: Male____Female____ Birthdate:_____Age:_____ Social Security#:_____

If Patient is a minor, Parent / Guardian's Name:_____

Patient's Street Address:_____

City, State, Zip Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email Address:_____

Emergency Contact Name and Phone Number:_____

Patient's Marital Status: Married___ Single____ Spouse Name_____

How did you hear about us? Supertalk 99.7_____ Friend/Family_____ Internet_____ Groupon____

Television____ Networking Event____ Other (Please Specify)_____

Reasons for visit (please be specific):_____

_____

_____

How will you pay today? Cash_____Check_____Credit Card_____ HSA/FSA Card _____

I understand payment in full is due at time of service.

I understand that a 24 hour notice is required for appointment cancellations and I will be charged a $49 fee if I fail to make my appointment without canceling at least 24 hours in advance.

Patient (or legal guardian) Signature_____

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Name: _____ **Date:** _____

Screening Questionnaire for Adult Immunization

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

Patient name:_____ DOB: ____/____/_____

Are you sick today?	Yes	No	Don't Know
Do you have allergies to medications, food, or any vaccine?	Yes	No	Don't Know
Have you ever had a serious reaction after receiving a vaccination?	Yes	No	Don't Know
Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorder?	Yes	No	Don't Know
Do you have cancer, leukemia, AIDS, or any other immune system problem?	Yes	No	Don't Know
Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had X-Ray treatments?	Yes	No	Don't Know
Have you had a seizure, brain, or other nervous system problem?	Yes	No	Don't Know
During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	Yes	No	Don't Know
For women: Are you pregnant or is there a chance you could become pregnant during the next month?	Yes	No	Don't Know
Have you received any vaccinations in the past 4 weeks?	Yes	No	Don't Know

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

Form completed by:_____ Date:_____

Form reviewed by:_____ Date:_____

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Name: _____ **Date:** ____/____/_____

Medical History

Psychiatric problems: Yes No Seizures: Yes No Gastrointestinal problems: Yes No

Irregular heartbeat Yes No Heart disease or surgery: Yes No Respiratory problems: Yes No

Psoriasis: Yes No Immunity problems: Yes No Immune suppression drugs: Yes No

Other:_____

Please explain any "yes" answers:_____

_____

Have you had any surgeries in the past year? Yes No If Yes, what kind?_____

_____

Please list all of your current medications.

Name of medication	Condition or reason for use	Name of medication	Condition or reason for use
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

The above information is complete and accurate to the best of my knowledge. I hereby consent to consultation and treatment/administration of vaccines by the physician provider. I understand that payment in full by cash or credit card is due at the time of the visit. Travel Clinics of America, LLC does not bill insurance or any third party payor, including Medicare. A portion of the charges may be reimbursable by insurance.

_____ ____/____/_____

Traveler/Parent/Guardian signature Date

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Name: _____ **Date:** _____

Travel Medical History Questionnaire

Have you previously traveled to a developing country? Yes No Are you traveling alone? Yes No

Departure Date: ____/____/_____ Return Date: ____/____/_____

Please List in order all countries you plan to visit and the length of stay:

_____

_____

_____

_____

Trip purpose (Circle all that apply): Business Vacation Study Missionary Visiting friends/relatives Safari Cruise Long stay Volunteer/Humanitarian work

Accommodations (Circle all that apply): Hotel 4/5 Star Hotel 2/3 Star Hostel Private Home Camping Safari Staying with locals Long-stay apartment Cruise ship

Trip Activities (Circle all that apply): Air travel Public transportation (bus, train, etc.) Biking Rental car Water sports (swimming, boating, etc.) Scuba/Snorkeling Climbing/Hiking Healthcare worker Visiting schools/hospitals/orphanages Contact with animals

Vaccines Administered (Clinic Use Only)

Td or TDAP	Hepatitis A	Hepatitis B
Influenza	IPV	Japanese Encephalitis
Menactra	Menomune	Rabies
Twinrix	Typhoid (Oral / Injectable)	Yellow Fever

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Name: _____ **Date:** _____

Do you have a written record of your vaccinations? Yes No (If yes, skip vaccine history below)

Vaccines	Date(s) received	Never had	Not sure	Had disease
Tetanus-Diptheria Vaccine (TDAP)				
Measles, Mumps, Rubella (2 doses)				
Polio, childhood series				
Polio, adult booster				
Chicken pox (Varicella, 2 doses)				
Meningitis (Menomune or Menactra)				
Pneumonia				
Influenza (flu)				
Hepatitis A (2 doses)				
Hepatitis B (3 doses)				
Typhoid (Oral or Injectable)				
Yellow Fever				
Japanese Encephalitis (2 doses)				
Rabies (3 doses)				
Other vaccines:				

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Name:_____ Date:____/____/_____

Physician Notes (Clinic Use Only)

BP:	P:	R:	TEMP:

Pre-Travel Counseling (Check all that apply)

Food and water	Medical care abroad	Personal safety
Traveler's Diarrhea self-treatment	Personal Rx	Accidents
Insect protection including Dengue	Altitude Illness	STDs/HIV
Malaria ABCD	Water sports	Alcohol and drug use
Fresh water risks	Climate risks: sun and frostbite	
Rabies avoidance	DVT avoidance	Fever in returning traveler
Travel Insurance	Medical Kit	Other Supplies

Medication	Common Dosing	RX Given
Azithromax	1000mg x 1 or 500mg QD x 3 d for T.D.	
Ciprofloxin	500mg BID x 3 d for T.D.	
Rifaximin	200mg QD while traveling	
Diflucan	150mg once for yeast infection	
Chloroquine	500mg QW (1-2 weeks before, 4 weeks after)	
Doxycycline	100mg DQ (1-2 days before, 7 days after)	
Malarone	250mg QD (1-2 days before, 7 days after)	
Mefloquine	250mg QW (1 week before, 4 weeks after)	
Ambien	5-10mg HS	

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Dr. Edward C. Leichner, D.O.
Robert M. Tomsett Jr., PA-C
Retha Thomas, FNP-BC
Jennifer Heinrich, PA-C

I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow up among the multiple healthcare provider's who may be involved in that treatment directly and indirectly.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices which contains a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the above address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

Print Patient Name: _____

If Guardian; Relationship to Patient: _____

Patient / Guardian Signature: _____

Today's Date: _____

……

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

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RELEASE AND ASSIGNMENT

I understand that in certain situations payment for services may not occur at the conclusion of my visit or in other cases, such as pathology services, GracePointe Healthcare may have to bill me for additional costs after my visit and that I am responsible for payment of all services rendered. I will pay all collection fees, court costs, attorney fees, and any other expenses required to reimburse GracePointe Healthcare, for services rendered.

Patient / Guardian Signature: _____ Date: _____

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I understand that GracePointe Healthcare uses automated appointment reminders that send emails, phone calls, and/or texts to remind me of my scheduled appointment. I consent to receiving these reminders and understand I can opt out at any time.

Patient / Guardian Signature: _____ Date: _____

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I understand that the office staff of GracePointe Healthcare may need to reach me via telephone. In the event I am unavailable, I authorize the office staff of GracePointe Healthcare to leave a message on my voicemail requesting a return call.

Patient / Guardian Signature: _____ Date: _____

.....

The office staff of GracePointe Healthcare may discuss my health care with the following individuals:

_____ _____
Name Phone Number / Relationship

_____ _____
Name Phone Number / Relationship

_____ _____
Name_____ Phone Number / Relationship _____

Patient / Guardian Signature:_____ Date: _____