PASSPORT HEALTH PATIENT INFORMATION/CONSENT

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CLIENT INFORMATION REVIEWED BY R.N.

____
R.N. INITIAL

NAME: ____
Last First Middle Initial

ADDRESS: ____
Street Apartment/Space #

____
City State Zip Code

BIRTHDATE: ____________________________ AGE:__________ ☐ MALE ☐ FEMALE

SOCIAL SECURITY # LAST 4 ONLY: _______________ 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:_________________

PHYSICIAN ADDRESS:____

Do you want us to send your primary care physician a copy of your immunization record? ☐Yes ☐No

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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

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 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 14 days.

____ ______________________

Client Signature/ Parent or Guardian if under 18: Sign & Print Name **Today's Date**