Travel Medicine Patient Demographics

ALL ITEMS BELOW MUST BE COMPLETED

Last Name: ______ First: ______ MI: ______.

Address: ______.

City: ______ State: ______ Zip: ______.

Date of Birth: ______ Gender: M or F ______ Marital Status: M S D W ______.

Home Phone: ______ Cell Phone: ______.

Spouse's Name: ______ Email Address: ______.

Parent / Guardian Name if Above Patient Is Under 18 Years Old: : ______.

Name of nearest relative not living with you: ______ Phone: ______

Who do we contact in case of an emergency? ______ Phone: ______

Primary Care Doctor's Name: ______ Phone: ______ Okay to send them Records? ☐Yes ☐ No

Employer Name (if traveling for business): ______ Work Phone: ______.

DENVER TRAVEL MEDICINE CLINIC, PC ("The Practice")

HIPAA PRIVACY CONSENT

By signing on page two of this form the above named patient or the guardian of the patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a "Notice of Privacy Practices" document and the patient/guardian has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Practices at any time
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

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FINANCIAL POLICY

By signing below I attest that I understand and agree to the following regarding fees for services provided by Denver Travel Medicine Clinic, PC:

1.) Claims/fees for services provided by Denver Travel Medicine Clinic are to be paid in full at time of service.

2.) If for any reason the above account related to the above named patient has a balance with Denver Travel Medicine Clinic for services or supplies rendered, the responsible party who signs below and/or the parent/guardian of the patient will be billed directly and will be fully responsible for any and all fees that are due. Checks returned unpaid will result in a $50 returned check fee added to the responsible parties account. A $50 billing charge will be added at 30 days to any outstanding balance the patient has with Denver Travel Medicine Clinic, PC in addition to any charges necessary for the collection of this debt. A 30% collection agency fee will be added if the patient account goes to collections.

3.) Denver Travel Medicine Clinic, PC is out of network with all medical insurance carriers and we do not submit claims/fees for services provided to medical insurance carriers. Denver Travel Medicine Clinic makes no guarantee any services or vaccines provided will be covered or reimbursed by your medical insurance carrier.

CONSENT TO TREAT:

By signing below, I hereby consent to evaluation, testing and treatment for me or the above named patient as directed by the physician or his or her designee at Denver Travel Medicine Clinic, PC.

By signing below, I certify I have read and understand and agree to the content ON PAGE THIS FORM including the HIPAA PRIVACY CONSENT, FINANCIAL POLICY, AND CONSENT TO TREAT.

➡ Signed:______________________________ Date:__________________

➡ This form/ consent was signed by (please print):______________________________

➡ Relationship of the person who signed to the patient: ☐Self ☐Parent ☐Guardian ☐Other:___________

DENVER TRAVEL MEDICINE CLINIC, PC
(collectively referred to here after as "MEDICAL PRACTICE")

➡ **Patient Name:**____ **Birth Date:**____________

MEDICAL INFORMATION RELEASE

By signing below, I authorize Denver Travel Medicine Clinic, PC to release ALL medical information for the above named patient to the individuals listed below. This information could include blood test results, x-ray results, consultation reports, sexually transmitted disease testing results, HIV testing results, information on mental disease and substance abuse, etc.

Person(s) who may receive my medication information:

➡ ☐ NONE

____

____

Information I DO NOT wish to share with the above named individual(s) includes:

➡ ____

____

☐Yes
I Authorize

➡

☐No
I Do Not Authorize

AUTHORIZATION TO LEAVE TELEPHONE MESSAGES REGARDING TEST RESULTS

There are times when it may be more convenient for our staff to leave you a detailed telephone message regarding testing results. These situations include normal testing results (normal blood work, negative strep test, normal xrays, etc) or slightly abnormal results that require no immediate follow-up. **Sensitive test results (i.e. positive HIV testing, etc) or testing results that require a new treatment plan ARE NOT left on answering machines or voice mails. In these situations we will leave a message for you to call our office or mail you a letter requesting follow up in our office.**

By checking the accept area to the left, I authorize South Denver Primary Care, PC dba Aspire Family Medicine to leave a message on my home or cell phone answering machine or voice mail regarding testing results. I understand telephones, cells phones, voice mail and answering machines may not be a secure form of communication. If you wish to decline, please check the appropriate area to the left.

☐Yes
I Authorize

➡

☐No
I Do Not Authorize

AUTHORIZATION TO SEND A TEXT MESSAGE APPOINTMENT REMINDER

I authorize MEDICAL PRACTICE to send text message appointment reminders to me on my provided cell phone number. I understand that text message charges from my cell phone provider may apply. I understand that text messages are not considered a secure or encrypted form of communication and is NOT HIPAA compliant. Please check appropriate box to the left.

☐Yes
I Authorize

➡

☐No
I Do Not Authorize

AUTHORIZATION TO SEND EMAIL MESSAGES

Periodically our practice sends out emails to your patients providing them updates on current medical issues we feel may be relevant to them (i.e. influenza vaccine clinics in our office, etc). We generally sent out these types of emails four times a year. We may also utilize email to send appointment reminders to our patients. **WE DO NOT SELL OR GIVE AWAY YOUR EMAIL!**

I authorize MEDICAL PRACTICE to send periodic emails and appointment reminder emails to me at the email address I have provided. I understand email is not a secure form of communication and is not HIPAA compliant. Please check appropriate box to the left.

By signing below, I certify I have read and understand and agree to the content. I have also initialed my choice regarding the AUTHORIZATION TO LEAVE TELEPHONE MESSAGES REGARDING TEST RESULTS, AUTHORIZATION TO SEND A TEXT MESSAGE APPOINTMENT REMINDER, AND AUTHORIZATION TO SEND EMAIL MESSAGES.

➡ Signed:____ Date:________________

Travel Medicine Consult – Patient History Form – Page 1 of 2

Patient Name:______________________________________ Birth Date:__________ Today's Date_________

Where did you hear about us? ☐ Internet search ☐ Travel Agent: ______________ ☐ Other:____________

Itinerary

Please described all locations/destinations you plan to travel to:

	Date of Arrival:	Length Of Stay:	Destination (Country and Region if Known):
1.)	____________	_______________	____
2.)	____________	_______________	____
3.)	____________	_______________	____
4.)	____________	_______________	____

Reason for travel (check all that apply): ☐ Vacation ☐ Business ☐ Volunteer Work ☐ Work/Study Abroad
☐ Other:____

Accommodations while traveling (check all that apply): ☐ Hotel ☐ Hostel ☐ Camping ☐ Cruise
☐ Other:____

Do you plan to travel to a farm or are you going to be participating in any agricultural work or development?
☐ Yes ☐ No

Do you plan to travel to locations that are above 8000ft in elevation? ☐ Yes ☐ No ☐ Unknown

Please indicate if you have had any of the following symptoms/conditions in the last 6 months (answer all items):

☐ No ☐ Yes – Fever / Chills
☐ No ☐ Yes - Fatigue
☐ No ☐ Yes - Nasal Congestion
☐ No ☐ Yes - Chest Pain
☐ No ☐ Yes - Shortness of breath
☐ No ☐ Yes - Coughing
☐ No ☐ Yes - Nausea
☐ No ☐ Yes - Vomiting

☐ No ☐ Yes - Abdominal Pain
☐ No ☐ Yes – Skin rash/changes
☐ No ☐ Yes - Joint swelling
☐ No ☐ Yes – Numbness / Tingling / Weakness
☐ No ☐ Yes - Seizures
☐ No ☐ Yes - Memory Loss
☐ No ☐ Yes - Headaches
☐ No ☐ Yes - Easy Bruising

☐ No ☐ Yes - Depression
☐ No ☐ Yes - Anxiety
☐ No ☐ Yes - Irritable
☐ No ☐ Yes - Difficulty with sleep
☐ No ☐ Yes - Suicidal thoughts

Women Only:
☐ No ☐ Yes - Pregnancy
☐ No ☐ Yes – Breastfeeding

Please indicate and list all of your CURRENT AND PAST MEDICAL PROBLEMS (answer all items):

☐ No ☐ Yes - Diabetes
☐ No ☐ Yes - High blood pressure
☐ No ☐ Yes - High cholesterol
☐ No ☐ Yes - Heart Attack
☐ No ☐ Yes - Stroke
☐ No ☐ Yes - Migraines
☐ No ☐ Yes – G6PD Deficiency
☐ No ☐ Yes – Asthma / COPD
☐ No ☐ Yes - Allergies

☐ No ☐ Yes - Arthritis
☐ No ☐ Yes - Anemia
☐ No ☐ Yes - Thyroid disease
☐ No ☐ Yes - Other Psychiatric Disorder
☐ No ☐ Yes – Alcohol / Substance Abuse
☐ No ☐ Yes – Insomnia
☐ No ☐ Yes - Depression

☐ No ☐ Yes - Anxiety
☐ No ☐ Yes - Seizures
☐ No ☐ Yes - Heartburn/Reflux
☐ No ☐ Yes - Sleep Apnea
☐ No ☐ Yes - Blood Clots
☐ No ☐ Yes - Bleeding disorders
☐ No ☐ Yes – Cancer

What type of cancer:___________
____

Please list any other medical problems you have and serious illnesses in the past including hospitalizations (other than surgery):____

Please list all SURGERIES you have had in the past (including the approximate date of those surgeries):

____

____

Please indicate if any of your SIBLINGS, PARENTS, GRANDPARENTS, or CHILDREN have any of the following medical conditions (please answer all items):

☐ No ☐ Yes - Heart Disease
☐ No ☐ Yes - Stroke
☐ No ☐ Yes - Substance Abuse
☐ No ☐ Yes - Depression/Anxiety
☐ No ☐ Yes - Blood Clots
☐ No ☐ Yes – Cancer
If cancer, what type:___________
____

Please list any other family medical conditions:____

Current Medications (please include NAME, DOSE, and HOW OFTEN YOU TAKE THE MEDICINE) – If you have a list, please attach:

1.)____
2.)____
3.)____
4.)____
5.)____
6.)____

Do you take any other over the counter medications or herbals?_________________________________

Do you use tobacco currently or in the past? ☐ No ☐ Yes **If yes**, how many packs/cans per day?________
When did you quit?___________

Do you drink Alcohol? ☐ No ☐ Yes - **If yes**, how many beverages (12oz beer, 5oz wine, or 1.5oz liquor) per week?______

Previous Vaccinations – Please indicate if you have ever received any of the following vaccinations by checking the appropriate box. If you have received any of the vaccinations below, please indicate what year they were administered:

-Hepatitis A-	☐Yes ☐No - I have received in the past If Yes: Did you receive **2 doses**? ☐Yes ☐No	**-Hepatitis B-**	☐Yes ☐No - I have received in the past If Yes: Did you receive **3 doses**? ☐Yes ☐No
-Tetanus-	☐Yes ☐No - I have received in the past Date Received:__________	**-Typhoid-**	☐Yes ☐No - I have received in the past Date Received:__________
-MMR (Measles, Mumps, Rubella)-	☐Yes ☐No - I have received in the past	**-Polio-**	☐Yes ☐No - I have received in the past ☐Yes ☐No - Have you had this immunization as an adult?
-Yellow Fever-	☐Yes ☐No - I have received in the past	**- Meningitis (Meningococcal)-**	☐Yes ☐No - I have received in the past Date Received:__________
- Japanese Encephalitis-	☐Yes ☐No - I have received in the past	**- Rabies-**	☐Yes ☐No - I have received in the past

Do you have any allergies to or had reactions to: ☐ No ☐ Yes - Medications? ☐ No ☐ Yes - Vaccinations?
☐ No ☐ Yes - Bee Stings? ☐ No ☐ Yes – Other (Foods, Environmental, etc)?
If yes to any of the above, please list____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can lead to a delay in diagnosis and can be dangerous and potentially fatal to my health. It is my responsibility to inform the doctor's office of any change in my medical status.

____ ____________________
Signature of patient or legal guardian Date

____
Printed name of individual signing form if it is not the named patient