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# Travel Medicine Clinic

## Patient Information Sheet

PATIENT ______________________________

Address ______________________________
CITY STATE ZIP

Home Phone __________ Cell __________ Business Phone __________

EMPLOYER __________ Occupation __________

Social Security No. __________ Date of Birth __________

RESPONSIBLE PARTY (If other than patient) __________

Home Phone __________ Cell __________ Business Phone __________

**WHO SHOULD BE CONTACTED IN CASE OF EMERGENCY:** __________

Home Phone __________ Cell __________ Business Phone __________

**PRIMARY CARE or FAMILY DOCTOR** __________ Phone __________

**I hereby authorize the above information is correct. I understand that these services may NOT be covered by insurance, and that this office DOES NOT submit to insurance for Travel. It is my responsibility to pay for all charges for the services of this Travel Medicine Clinic at the time of the visit. (*Credit Card* or *Cash Only*)**

__________ Signature __________ Date

**FOR FOLLOW-UP VISITS:** Please review above information. Initial and date below if unchanged.

| Date | Initial | Date | Initial |
|---|---|---|---|
| Date | Initial | Date | Initial |

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