The International Travel Clinic

LAST NAME_____ FIRST NAME_____ MIDDLE INITIAL___

BIRTHDATE ___/___/___ SOCIAL SECURITY_____ M____ F_____

HOME ADDRESS_____ ZIPCODE_____

TELEPHONE NUMBERS
HOME_____ OFFICE/CELLULAR_____ FAX_____

PARENT/GUARDIAN NAME _____( )_____

PRIMARY CARE PHYSICIAN_____ TELEPHONE _____

DO YOU WANT US TO NOTIFY YOUR PHYSICIAN OF THIS VISIT? Y____ N____

IN CASE OF EMERGENCY, WHO DO WE CONTACT?_____
TELEPHONE_____

DO YOU/ YOUR CHILD HAVE ANY MEDICAL CONDITION THAT WARRANTS

MAINTENANCE MEDICATIONS OR FOLLOW-UP? Y_____ N_____
EXPLAIN_____

DO YOU/YOUR CHILD HAVE A FEVER, COUGH, OR SORE THROAT?Y__N ____

HAVE YOU/ YOUR CHILD HAD ANY OPERATIONS? Y____ N_____

HAVE YOU/ YOUR CHILD HAD ANY BLOOD TRANFUSIONS OF BLOOD OR BLOOD PRODUCTS RECENTLY? Y_____ N_____

HAVE YOU/ YOUR CHILD EVER BEEN HOSPITALIZED FOR ANY ILLNESS?
Y_____ N____ EXPLAIN_____

DO YOU/YOUR CHILD HAVE ANY ALLERGIES? Y___ N_____
EXPLAIN_____

ANY ADDITIONAL INFORMATION:
_____
_____
_____

ASSIGNMENT AND RELEASE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DR. MAVUNDA FOR ALL INSURANCE BENEFITS OTHERWISE PAYABLE FOR PROFESSIONAL SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT COVERED OR PAID BY INSURANCE.

I AUTHORIZE DR. MAVUNDA AND HER STAFF TO RELEASE THE INFORMATION REQUESTED FOR PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS. I HAVE READ ALL THE INFORMATION AND HAVE COMPLETED THE ABOVE QUESTIONS. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY STATUS OR THE ABOVE INFORMATION.

Signature of Responsible Party: _____
Relationship to Patient: _____
Today's Date: _____