THE TRAVEL CLINIC 1200 Hilyard St., Suite 560, Eugene OR USA 541.343.6028

name_________________________________ home phone _________________ today's date________/_______/_______

address (not post office box)___________________________ city_________________ state________ zip ___________

mailing address (like PO Box)__________________________city _________________state ________ zip ___________

work phone _______________ email address__________________________ your birthdate _______/______/_______

who told you about us?____________________________ name of your medical insurance________________________

* * * * * * * * * * * * * Please take the time to make this information **complete** and **accurate** * * * * * * * * * * * * * *
* * * * * * * * * * * * * * * since it will determine what kind of disease protection you need. * * * * * * * * * * * * * * *

departure date______/_______/______ return date_______/_____/______

countries you plan to visit (please list in sequence):

country	urban	rural	for how long?	purpose of your visit (what you will be doing)
______________________	☐	☐	________	__________________________________
______________________	☐	☐	________	__________________________________
______________________	☐	☐	________	__________________________________
______________________	☐	☐	________	__________________________________
______________________	☐	☐	________	__________________________________
______________________	☐	☐	________	__________________________________

* *

prior immunizations:

	received vaccine before?				last booster?	
	yes	prob-ably	no	don't know	approx. date	don't know
yellow fever	☐	☐	☐	☐	______________	☐
polio	☐	☐	☐	☐		☐
hepatitis B	☐	☐	☐	☐	______________	☐
meningococcal	☐	☐	☐	☐	______________	☐
measles or MMR	☐	☐	☐	☐		☐
oral typhoid	☐	☐	☐	☐	______________	☐
injectable typhoid	☐	☐	☐	☐	______________	☐
tetanus-diphtheria	☐	☐	☐	☐		☐
pneumococcal pneumonia	☐	☐	☐	☐	______________	☐
rabies vaccine	☐	☐	☐	☐		☐
hepatitis A VACCINE	☐	☐	☐	☐	______________	☐

influenza vaccine last dose_____________

* *

Check if you have had these diseases: measles ☐ hepatitis A ☐ chicken pox ☐

Who is your regular doctor?____

If your doctor does not practice in Eugene or Springfield, what is the address? _______________________________

A report of the vaccines you receive will be sent to your doctor unless you do not approve.

PLEASE COMPLETE BOTH PAGES OF THIS FORM

Please initial either 1 or 2, but not both:

1. ____ I give permission to Dr. Wilson to correspond with me about my itinerary, prior immunization record, general medical history, medications and his recommendations by email using any of the contact information I have given him. Dr. Wilson is given this permission for an indefinite period of time.

- OR -

2. ____ I do not give permission to Dr. Wilson to use email for the above information. I will inform Dr. Wilson which items may be discussed by email.

MEDICAL HISTORY (please check if true):

☐ I was raised outside of the USA.
☐ I am not sure I received all childhood vaccines.
☐ I have had allergic reaction to eggs (can't eat eggs).
☐ I am allergic to thimerosal (a mercury derivative).
☐ I have fainted after shots or drawing blood.
☐ I have had an allergic reaction to any vaccine.
☐ My spleen or thymus has been removed.
☐ I am taking antibiotics now.
☐ I have taken cortisone/steroids not on skin in the past 3 months.
☐ I am pregnant now, or may be pregnant now, or may become pregnant before or during my trip.

I have or have had these medical problems:

☐ diabetes	☐ bowel disease
☐ high blood pressure	☐ kidney disease
☐ seizures	☐ lung disease
☐ psychosis	☐ liver disease
☐ heart rhythm problem	☐ heart disease
☐ prostate problem	☐ asthma
☐ cancer	☐ ulcers
☐ lymphoma	☐ cancer chemotherapy
☐ radiation therapy	☐ immune deficiency

I am allergic to these medicines: _____

Please list your current medicines:

_____

_____

The above information is complete and accurate. I request and consent to the administration of the vaccines to myself (or to the patient if I am the parent or guardian) agreed upon by myself and Dr. Wilson.

I understand that deposit payment is due at the time services are delivered. I am financially responsible for charges for services rendered to me by John D. Wilson, M.D. LLC (dba The Travel Clinic). I request that payment of insurance benefits be made on my behalf to Dr. Wilson for any services furnished to me. I authorize any holder of medical or other information to release to my insurance provider any information needed to determine benefits under my insurance plan. I authorize my insurance provider to make payment directly to Dr. Wilson. I understand that Dr. Wilson will, as a courtesy, bill my insurance provider on my behalf. I agree to pay Dr. Wilson the difference between the approved charge (as determined by my insurance company) and the amount my insurance company pays to Dr. Wilson according to the agreement I have with my insurance provider. If my insurance pays on a given item, I understand that I may be eligible for a refund of the deposit for that item. I understand that there will be a charge for missed appointments not cancelled within 24 hours. *If my insurance is managed care insurance, and no referral is in place, I understand that I am accepting financial responsibility in signing this waiver.* I understand that if I fail to pay in full on time, I agree to reimburse Dr. Wilson for all costs of collection, including reasonable attorney fees and costs, and to pay interest at the statutory rate.

Please see our Financial Policy which will clarify some of these issues.

_____ _____/_____/_____

(signature of traveler and parent/guardian) (date)

PLEASE COMPLETE BOTH PAGES OF THIS FORM