

## Travel Patient Information Form

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Age \_\_\_\_\_  
 Gender M/F Last Menstrual Period \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
**Best** Phone Number to reach you \_\_\_\_\_  
 Email \_\_\_\_\_  
 How did you hear about us? \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
 Employer Address: \_\_\_\_\_  
 Employer Telephone Number: \_\_\_\_\_  
 Primary Care Physician, City, State \_\_\_\_\_  
 Date of last Physical Exam \_\_\_\_\_  
 Emergency Contact Name/Number \_\_\_\_\_

**Travel Plans**

Departure Date \_\_\_\_\_ Return Date \_\_\_\_\_

Countries to be visited (in order)	Length of stay

Reason for Trip: Business/Tourist/Student/Volunteer/Other \_\_\_\_\_  
 Will your travel include urban/rural/both?  
 Will your travel include any overnight backpacking? Y/N  
 Accommodations: Hotel/Youth Hostel/Private Home/Camping/Tent/Cruise/Other

**Medical Problems/Illness/Injury**

Please indicate if you have had/have any of the following:

- |  |  |
|--|--|
| Mental Illness/Depression<br>Seizure disorder<br>High blood pressure<br>Diabetes<br>Ulcers<br>Heart trouble<br>Chest pain<br>Heart murmur<br>Stroke<br>Cancer<br>Hepatitis | Gallstones<br>Kidney stones<br>GI bleeding<br>Diverticulitis<br>Thyroid problems<br>Lung disease/asthma<br>Shortness of breath<br>Accidents/broken bones<br>Skin disease<br>Bleeding disorder/anticoagulants<br>Other: |
|--|--|

List any hospitalizations or surgeries:

**Pregnant?: Yes/No**

**Breastfeeding?: Yes/No**

Current Medications (list):include over the counter

Allergies: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you allergic specifically to? Bee stings/Eggs/Thimerosal/Latex/Gelatin/Sulfa/Streptomycin

Are you pregnant or trying to get pregnant? Yes/No

Are you nursing? Yes/No

Have you ever had an adverse reaction to a shot? Yes/No

Do you have a history of an immune disorder (i.e. cancer or HIV) Yes/No

Do you LIVE WITH someone who has HIV, cancer, or is taking Prednisone, steroids or chemotherapy? Yes/No

**Immunization History (Don't Forget to Bring in Your "Yellow Card"!!)**

Vaccine	Year	Vaccine	Year
Hepatitis A Vaccine		Rabies	
Hepatitis B Vaccine		Tetanus	
Immune Globulin		Typhoid	
Influenza		Varicella (chickenpox)	
Japanese E		Yellow Fever	
MMR		Herpes Zoster	
Meningitis		Gardasil	
Polio		Pneumococcal	

***I understand that I will be charged a consultation fee for today's visit of \$50 in addition to the cost of each vaccine. If vaccines are not administered, the office fee is \$110. I am aware that all fees are due at the time services are rendered, unless other arrangements have been made in advance. I have been given the opportunity to or have reviewed FMTC's "Notice of Privacy Practices" as required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).***

The above information is true and accurate.

Patient signature: \_\_\_\_\_

Date: \_\_\_\_\_



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[www.farragutmedical.com](http://www.farragutmedical.com)

### **Notice of Privacy Practices**

**To our patients:** This notice describes how health information about you (**as a patient of this practice**) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 199 (HIPPA)

### **Our commitment to your privacy**

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information.

### **Use and disclosure of your health information in certain special circumstances:**

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.

7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers' Compensation and similar programs.

### **Your rights regarding your health information**

1. Communications: You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you ask that we contact you at home, rather than work. We will accommodate reasonable request.
2. You can request a restriction in our use or disclosure of you health information for treatment, payment, or health care operations. Additionally you have the right to request that we restrict our disclosure of you health of your care; such as family members and friends. We are not required to agree to your request, however, if we do agree we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Farragut Medical & Travel Care 202-775-2464 HIPPA Officer.
4. You may ask us to amend you health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Farragut Medical & Travel Care 202-775-2464/ 815 Connecticut Avenue NW Washington, DC 20006 Attention HIPPA Officer. You must provide us with a reason that supports your request for amendment.
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Service. To file a complaint with our practice, contact Farragut Medical & Travel Care 815 Connecticut Avenue NW Washington, DC 20006 Attention HIPPA Officer 202-775-2464. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain you written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Farragut Medical & Travel Care 815 Connecticut Avenue NW Washington, DC 20006 Attention HIPPA Officer.