

Travel Medicine Clinic
Valley Infectious Disease Associates

Patient Registration Form

Name: _____ Birth Date: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____-_____-_____ Home Phone: _____-_____-_____ Cell: _____-_____-_____

Employer: _____ Phone: _____-_____-_____

Referred/Ordered by: _____

Emergency Contact: _____ Phone: _____-_____-_____

Non-traveling patients: reason for vaccination: _____

If traveling, Departure Date: _____ Destination(s) and length of stay: _____

Other Family Members being consulted:

Name: _____ M/F DOB: _____ SS#: _____-_____-_____

Name: _____ M/F DOB: _____ SS#: _____-_____-_____

Name: _____ M/F DOB: _____ SS#: _____-_____-_____

Name: _____ M/F DOB: _____ SS#: _____-_____-_____

Valley Infectious Disease Associates
Travel and Immunization Services

I understand all professional services rendered are charged to the patient and fees are collected at the time of service. I understand I am responsible for all fees, regardless of insurance coverage.

I understand Valley Infectious Disease Associates is a separate business, with a separate business license and Tax-ID number from the physician's medical practices. I understand Valley Infectious Disease Associates Travel Medicine Clinic has no contracts with insurance carriers.

I have read and understand the above information.

Name: _____ Date: _____