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: ____-____-____

How did you hear about us? Internet/Google____Yellow Pages____ Physician referral_____

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: _____