Travel Medicine Clinic
Valley Infectious Disease Associates

Patient Registration Form
Haitian Medical Relief Volunteers

Name: _____Birth Date: _____ Gender: _____

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

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

Employer: _____ Occupation:_____ Phone: ____-____-____

Referred/Ordered by: _____

Emergency Contact: _____ Phone: _____-_____-____

Departure Date: _____ Length of stay: _____

Do you expect to be working outdoors extensively? If so, explain: _____

Expected relief work activities: _____

_____

_____

_____

_____

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 or volunteer group reimbursement.

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: _____