Main Family Medical

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Travel Clinic Intake Form

Traveler's Name _____
Contact Phone_____
DOB _____

Complete Travel Itinerary (Cities and Countries in order – and include any layovers):
_____
_____
_____

Departure Date _____
Duration of Travel _____

Major Medical Conditions of Traveler? _____

***Note: It is very important that you send ALL immunization records that you can gather along with this form. You may need to call the providers or offices where you received these, or even your school or employer if you ever supplied them with your records. If there are absolutely no records for your vaccines, please try to answer vaccine questions below:**

Has the traveler had the following vaccinations?

Hepatitus A: _____ Hepatitus B: _____ Meningococcal (meningitis):_____
Tetanus:_____ Varicella:_____ MMR:_____
Yellow Fever: _____ Typhoid: _____

Medication Allergies_____

Has the patient been seen here previously? _____
Who is the patient's primary care provider? _____

How did you hear about our travel clinic? _____

Statements to the client

Full payment expected at the time of service. Estimated charges will be given prior to the visit with the provider, but may change based on medical decision making in the visit. If you have insurance, we will bill them after your appointment. Please note most insurance companies do not cover travel vaccines.

_____
Signature of Patient/Guardian

_____
Date

*Please submit signed form and immunization records to info@mainfamilymedical.com OR fax to (208) 336-9284.