Peachtree Travel Clinic **Client Completes Parts 1 to 6**

New Client Form

PART 1

NAME:		DATE OF CLINC VISIT:
DATE OF BIRTH:	AGE:	LAST FOUR OF SSN:
PRIMARY PHYSICIAN:		HOME TELEPHONE:
HOME ADDRESS:		WORK TELEPHONE:
		EMAIL ADDRESS:

PART 2

How did you hear about us? (Please check the appropriate category):							
☐	Physician	☐	CARE International	☐	Home Depot	☐	TVSA
☐	Travel Agent	☐	AT&T	☐	Employer	☐	
☐	Friend/ Family	☐	Mission Group	☐	Internet/ Advertisement	☐	

PART 3

ALLERGIES:	Have you ever had:	No	Yes	Is there a family history of mental health problems?	No	Yes
MEDICAL HISTORY:	Seizures	☐	☐			
	Irregular heartbeat	☐	☐		☐	☐
	Psoriasis	☐	☐	Are you allergic to eggs or egg products?		
	Depression	☐	☐		☐	☐
	Are you pregnant?	☐	☐			
MEDICATIONS:						

PART 4

COUNTRIES TO BE VISITED	ARRIVAL DATE	DEPARTURE DATE
Have you ever traveled before and if so, to where:		

TYPE OF TRAVEL FOR THIS TRIP								
☐	Urban/ City	☐	Adventure	☐	Mission Work	☐	Visiting Family
☐	Rural	☐	Business	☐	Relocating	☐	

PART 5

IMMUNIZATION HISTORY					
Immunization	Date	Immunization	Date	Immunization	Date
Tetanus/Diphtheria		Polio		Typhoid	
Hepatitis A #1		Hepatitis A #2		Yellow Fever	
Hepatitis B #1		Hepatitis B #2		Hepatitis B #3	
Japanese Encephalitis #1		Japanese Encephalitis #2		Japanese Encephalitis #3	
Meningococcal		Measles/Mumps/Rubella			

PART 6

All professional services rendered are charged to the client with the exception of corporate accounts with prior payment arrangements. Many insurance companies do no cover vaccinations. We therefore require payment at the time of service. You will receive a copy of your bill that you can submit to your insurance company for proper reimbursement.
I have read and agree to the above conditions:

_____ _____
Client Signature **Date**

_____ _____
Nurse/ Physician Signature Date