

# Patient Registration Form

(Please Print Clearly)



**NAME:** \_\_\_\_\_  
Last First M.I.

**EMAIL:** \_\_\_\_\_ **BIRTH DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**SEX:**  Male  Female **RACE/ETHNIC:**  White  African-Amer.  Asian  Hispanic/Latino  Other

**ADDRESS:** \_\_\_\_\_  
No. Street Apt. City State Zip

**PHONE:**  HOME  OFFICE ( ) \_\_\_\_\_ - \_\_\_\_\_ **CELL:** ( ) \_\_\_\_\_ - \_\_\_\_\_

**EMERGENCY CONTACT** \_\_\_\_\_  
Name Relationship Phone

**ALLERGIES** to foods or medicines: \_\_\_\_\_

**HOW DID YOU LEARN ABOUT IMU: (CHECK ALL THAT APPLY)**

- I have been here before
- Referred by my doctor/clinic (name, phone) \_\_\_\_\_
- Web search
- Referred by my school/employer (name) \_\_\_\_\_
- Ad
- Referred by my friend/family/other (name) \_\_\_\_\_

**Consent for Medical Care, Record Keeping, Privacy Notice, and Payment Responsibility**

I, as the client/patient, agree to receive care from a health care provider at the IMU Southwest, Immunization Clinic. I give consent for examination, immunization, blood or skin testing, medical advice, and other services from my IMU provider. (2) I understand that it is my responsibility to pay for services received. (3) I acknowledge that I have had the opportunity to read or receive a copy of the "Notice of Privacy Practices" (posted). (4) I understand that IMU email transmission may not be secure against unauthorized disclosure, and I hereby authorize that IMU may send my health information to me via unsecure email, but only upon my specific request to receive such information by email. (5) The IMU Southwest Clinic will keep this record in you or your child's medical file. It records what vaccine(s) and/or test(s) were given, the date when the vaccine(s) and/or test(s) were given, the name of the company that made the vaccine(s) and/or test(s), the lot number of the vaccine(s) and/or test(s), and the address where the vaccine(s) and/or test(s) were administered. (6) By signing the form below, you hereby freely and voluntarily give your permission and are requesting that the vaccine(s) and/or test(s) indicated by your signature(s) below be given to you or the person named below for whom you are authorized to make this request. (7) I understand the risks and benefits of the test/vaccine being given to me and have the opportunity to read The Vaccine Information Sheet "VIS" on each vaccine, or a "Subject Information" pamphlet on each test, as stated by law, for me to read BEFORE I receive your shots and/or test(s). Your signature below indicates that you have read, or have had the information explained to you and that you understand the benefits and risks of each vaccine administered. You hereby release and agree to hold harmless The IMU Southwest Clinic, its Officers, and Employees for any and all liability, of any kind or nature whatsoever, which might arise out of or result from any vaccine(s) and/or test(s) administered to you or your child.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**If client is a minor:**

Print name of parent/ guardian: \_\_\_\_\_

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**For Clinic/Office Use Only Vaccine Information Statements (VISs) as of August 6, 2016**

Varicella 3/13/08	DTap 5/17/07	Hib 2/4/14	Hepatitis A 7/20/16	HPV Cervix 5/3/11	Influenza 8/7/15
Polio 7/20/16	PCV 13 11/5/15	MMR 4/20/12	Hepatitis B 7/20/16	HPV9 Gardasil 3/31/16	Shingles 10/6/09
Rabies 10/6/09	PPSV 4/24/15	MMRV 5/21/10	Meningococcal 10/14/11	Japanese Enceph 1/24/14	Typhoid 5/29/12
Td/Tdap 5/9/13 2/4/14	Yellow Fever 3/30/11		Multi-Vaccine 11/5/15	Rotavirus 4/15/15	

# SCREENING QUESTIONNAIRE FOR INTERNATIONAL TRAVEL

Medical History of: (your name) \_\_\_\_\_

Occupation (This is for CDC data purposes): \_\_\_\_\_

Should we send a copy of your Immunization record to your Primary Physician? Yes \_\_\_ No \_\_\_

If yes, give us as much information as you know on your physician:

Primary Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Office Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## Destination of Travel:

1. Where are you going? [Please list countries and areas within countries, rural vs. urban]: \_\_\_\_\_

2. Date of Departure: \_\_\_\_\_ Date of Return: \_\_\_\_\_

3. Purpose of Travel (This is for CDC data purposes): Business \_\_\_ Pleasure \_\_\_ Mission \_\_\_ Study \_\_\_ Service \_\_\_

4. Name of Church or Business Affiliation for the trip: \_\_\_\_\_

## Health History

Allergies: \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Medications: [Please list all medications currently being taken]

Prescription: \_\_\_\_\_

Non Prescription: \_\_\_\_\_

Medical Conditions: \_\_\_\_\_

Previous Surgery(s): \_\_\_\_\_

Check if you have present or past history of the following: Nightmares  Psoriasis  Psychiatric Disorders/Depression   
Seizures/Epilepsy  Stomach/Colon  Problems

I verify that the above information is complete and correct to the best of my knowledge:

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_