

OFFICE USE <input type="checkbox"/> Client entered <input type="checkbox"/> Dr. Entered <input type="checkbox"/> Records Sent Client Information Reviewed by R.N. <hr/> R.N. INITIAL
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PASSPORT HEALTH PATIENT INFORMATION/CONSENT

Please Print

NAME: _____
Last
First
Middle Initial

ADDRESS: _____
Street
Apartment/Space #

City
State
Zip Code

BIRTHDATE: _____ AGE: _____ SEX: MALE FEMALE

E-Mail: _____ HOME PHONE: _____
AREA CODE

EMPLOYER: _____ WORK PHONE: _____
AREA CODE

EMPLOYER ADDRESS: _____
Street
Suite #

City
State
Zip Code

OCCUPATION: _____

HOW DID YOU HEAR ABOUT PASSPORT HEALTH: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

PHYSICIAN ADDRESS: _____
Do you want us to send your primary care physician a copy of your immunization record? yes no

Chronic Illnesses: _____

No known allergies to medications. Medication allergy to: _____

Allergic to eggs, feathers, yeast, mercury, quinine, formaldehyde or insect/bee stings? yes no

Current medications (including oral contraceptives): _____

Are you receiving steroid medications such as cortisone or prednisone? yes no If yes, name: _____

Are you receiving radiation or other treatments? yes no If yes, type: _____

Are you pregnant now or is there a possibility that you might be pregnant? yes no If yes, months: _____

Have you had an allergic reaction to an immunization in the past? yes no If yes, what? _____

Have you had a positive TB skin test in the past? yes no

I understand that payment for services is expected at the time of service by cash or credit card. I give permission to Passport Health to release medical information to my physician at my direction. I give my consent for immunization administration and understand that I will receive written information about possible side effects. I understand that it is recommended that I remain in the office for at least 15 minutes following an injection.

Client Signature/Parent or Guardian if under 18

Today's Date