IHA Midwest Travel Care – Traveler Worksheet

Traveler Name: ______________________ Birthdate: ________ Appt. Date: ________

Gender: ❑M ❑F Lifestyle: ❑Single ❑Married ❑Life Partner ❑Divorced ❑Widowed

❑Child < 18 If minor child, name of adult chaperone for immunizations: ________________

Driver License # or SSN – (if child, may use parent ID): ______________________

Current Address: ______________________ City: ________________

State: ________ Zip: ____________ E-Mail: ________________

Home Phone: ________________ Other Phone: ________________

Employer Name: ________________ Work Phone: ________________

If the **current address** above is **not** a permanent address, please list a relative's address where we can send correspondence.

Name: ________________ Relationship to traveler: ________________

Address: ______________________________________

City: ________________ State: ________ Zip: ____________

Family Travelers

Family Travelers last name must match last name of traveler at top of page. If not, please use separate worksheet

Name: ________________ Birthdate: ________ Gender: ❑M ❑F ❑child under 18

Driver License # or SSN – (if child, may use parent ID): ______________________

Name: ________________ Birthdate: ________ Gender: ❑M ❑F ❑child under 18

Driver License # or SSN – (if child, may use parent ID): ______________________

Name: ________________ Birthdate: ________ Gender: ❑M ❑F ❑child under 18

Driver License # or SSN – (if child, may use parent ID): ______________________

Insurance

Do you have a referral for this visit? ❑Yes ❑No

Primary Care Physician Name: ______________________

Primary Insurance Company: ______________________ Co-pay: $ ________

Member or Contract#: ________________ Group#: ________________

Name of Policyholder: ________________ Relationship to traveler: ________

Policy Holder Birth Date: ________________ ID or Social Security#: ________________

Policyholders place of employment: ______________________

Secondary/**Prescription** Insurance: ______________________ Co-pay: $ ________

Member Contract#: ________________ Group#: ________________

Name of Policyholder: ________________ Relationship to traveler: ________________

Policyholder Birth Date: ________________ ID or Social Security#: ________________

Policyholders place of employment: ______________________

May we mail vaccine reminders? ❑Yes ❑No

Phone appointment reminders? ❑Home ❑Work ❑Cell ❑None Leave message? ❑Yes ❑No

By signing this form, I agree to:

- Authorize treatment IHA Midwest Travel Care
- If staff is exposed by a sharps incident, I provide a blood specimen to rule out possible blood borne disease.
- Release medical information to insurance carrier(s) to request payment for all patients named on this form.
- Acknowledge that all Patients named on this form have received IHA Notice of Privacy Practices

______________________ ______________________ ____________

Patient/Parent or Guardian Name (Signature) Print Full Name Date