Middlesex Health
Infectious Disease & Travel Clinic
80 S.Main Street Middletown, CT 06457 P: 860.358.6878 F: 860.358.8692

Name:_____DOB:_____Age:_____

Travel Information:

Previous travel outside the US that required vaccination? Yes:_____ No:_____

Pharmacy: _____

Itinerary (Please list cites, countries and dates of travel)

Departure Date:_____Return Date: _____ Total length of trip _____

City/Country of travel _____ Dates:_____

City/Country of travel _____ Dates:_____

City/Country of travel _____ Dates:_____

Purpose of travel:

☐ Vacation ☐ Visit Family/Friends ☐ Teach/Study Abroad ☐ Adoption
☐ Other:_____

Accomodations:

☐ Hotel ☐ Resort ☐ Camping ☐ Dorm ☐ Private home ☐ Other: _____

Activities:

☐ Altitude >8,000ft ☐ Ocean/Salt water ☐ Rivers,lakes/fresh water
☐ Field work ☐ Animal Contact ☐ Scuba diving/Snorkeling
☐ Rafting/Kayaking ☐ Other: _____

Personal Medical Information:

Allergies: _____

Current Medications:

_____ _____
_____ _____
_____ _____

☐ **Yes** ☐ **No** Have you had a Splenectomy
☐ **Yes** ☐ **No** Have you had a Thymectomy
☐ **Yes** ☐ **No** Do you have history of Guillain-Barre Syndrome?
☐ **Yes** ☐ **No** Have you received a vaccine in the past four weeks? If yes, What and when_____
☐ **Yes** ☐ **No** Have you taken prednisone or other steroids, anti-cancer drugs, or medications that may affect your immune system in the last 3 months? If yes, what and when _____

Females:

☐ **Yes** ☐ **No** Are you pregnant, planning on becoming pregnant? If Yes, when:_____
☐ **Yes** ☐ **No** Are you currently breastfeeding?

Middlesex Health
MultiSpecialty Group

(860) 358-6878 / Fax (860) 358-8692

I have received the travel packet, which includes a list of travel-related expenses I may incur regarding my travel clinic visit today.

These expenses include a counseling fee and individual vaccines. I will also be responsible for filling any prescriptions at my own cost which the physician may prescribe.

I will be responsible for the balance of all services that are not paid by my insurance. It is my responsibility to understand what is covered by my insurance.

_____ _____

Signature / Name Date

Middlesex Health
MultiSpecialty Group

Please Print

Patient Name:_____

Home Address:_____

Mailing Address:_____

Town , State, Zip :_____

Please circle your preferred method for us to contact you: text / phone call

Phone: (home)_____[ ]
(work)_____[ ]
(cell)_____[ ]
(other)_____[ ]

Sex: M or F or T Month/Day/Year of Birth:_____
Marital Status_____Married Divorced Other_____
E-mail address:_____
Race:_____Ethnicity:_____
Social Security #:_____
Employer:_____
Referring Physician:_____
Primary Care Physician:_____
Pharmacy:_____

Emergency Contact: (name)_____
(phone)_____

Insurance Company: _____
Subscribers Name:_____ Date of Birth:_____
Member I.D:_____Group Number:_____
Employer:_____
Your relationship to the subscriber:_____

12/3/18

Middlesex Health

Outpatient Services / Office Visits
Patient Record of Disclosures

Notification of Disclosures to Persons Involved in Your Care

(This form may be used for all other hospital services and Off-site Locations.)

Patient Name:_____ **DOB:**_____

Permission to disclose information by telephone or by mail:

☐ No, I do not wish to have information via phone message or written communication.

☐ Yes, I wish to be contacted in the following manner:

Home #:	Work #:	Cellphone #:
☐ Leave a message with detailed information ☐ Leave a message with the call-back number only	☐ Leave a message with detailed information ☐ Leave a message with the call-back number only	☐ Leave a message with detailed information ☐ Leave a message with the call-back number only

☐ Written Communication
- ☐ Mail to my home address:_____
- ☐ Mail to my work/office address:_____
- ☐ Fax to this number:_____

☐ Other:_____

Permission to disclose information to family or other persons involved in your care

Unless you specifically agree, we will not disclose any information to family or other persons involved in your care either by phone or in person. This means, for example, that we will not be able to answer questions about a prescription, bill, schedule appointments or otherwise discuss your care or treatment with anyone other than you.

☐ No, I do not wish to have information shared with family or other persons involved in my care.

☐ Yes, I would like MHS to be able to discuss information related to my care with specific persons, listed below:

Name	Phone number	Relationship to Patient

_____ _____
Signature of Patient or Personal Representative Date

_____
Relationship to Patient