



Med Center Health.

Infectious Disease &
Travel Medicine Specialists

We are pleased to welcome you to our practice! Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner.

- Please bring your driver's license or government-issued photo identification card, insurance card, and all your prescription and over-the-counter medications or medication list with you to each visit.
- Our office will collect co-pays and any owed amounts at the time of each visit.
- If you are new to our practice, or if you have only been seen in the hospital and this is your first visit to our outpatient office, please arrive at least 15 minutes before your appointment time to complete new patient paperwork.
- Please arrive on time for your visit. If you arrive late, you may be asked to reschedule your appointment.
- We strive to notify our patients of their testing results within one week. If you have not heard from our office in that timeframe, please contact us.
- If you cannot attend your appointment, please notify us as soon as possible. We monitor all "no show" appointments. After three (3) "no-shows", you may be discharged from our practice.

On behalf of our entire staff, we look forward to seeing you! Please call us at 270-780-2760 should you have any questions or concerns before your appointment.

Sincerely,

Medical Center Infectious Disease Staff

INFECTIOUS DISEASE AND TRAVEL MEDICINE SPECIALISTS
PATIENT INFORMATION
Please Complete in Full, Sign and Date

Last Name: _____ First _____ Middle _____ Sex: _____

Marital Status: _____ Spouse's Name: _____

Social Security Number: _____ Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell/Message/Other Phone: _____

E-Mail Address: _____

Employer: _____ Occupation: _____

Employer's Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Employed (please check): Full Time Part Time Student

Ethnic Origin: W B H I Other _____ Patient declines to answer: _____

Are you allergic to any medications? _____ If so, list: _____

Emergency contact (a person that does **not** live in the same household!)

Name: _____

Phone: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

*****Please give the receptionist your current insurance card so a copy can be placed in your file

Insurance Name: _____ Insured's Name: _____

Insurance Address: _____ Insured's DOB: _____

INSURED SPOUSE OR PARENT INFORMATION

Name: _____ Relationship to patient: _____

Social Security No: _____ Birthdate: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

Employer's Mailing Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ **Date:** _____ **Time:** _____

Please check one:

- I **have** executed an advanced directive (Living Will)
- I **have not** executed an advanced directive (Living Will)
- I **would** like information on advanced directives

Med Center Health Infectious Disease & Travel Medicine Specialists

THE TRAVELER HEALTH HISTORY

Name _____ Age: _____ Today's Date: _____

Travel Destination(s) _____ Travel dates: _____

Preferred Pharmacy: _____

Purpose of Trip: pleasure _____ missionary team _____ work _____ medical Care _____
 study _____ other: _____

Travel companions: family _____ children _____ other adults _____ alone _____

Food Source: Natives/Local _____ Bringing own _____ Resort/Hotel _____

Water Source: Natives/Local _____ Bringing own _____ Resort/Hotel _____

Other exposures expected: Rainforest _____ Unsanitized Water _____ Animals _____ Fowl _____

Medical History: seizures _____ migraine Headaches _____ altitude Sickness _____
 lung problems _____ depression _____ stomach problems: _____
 blood Disorders _____ other: _____

Allergies (please list): _____

Medications (please list with dosage/frequency: _____

Social History: Smoker? _____ Alcohol 2x a week or more? _____ Recreational drugs? _____

Family History (mother/father): _____

ROS: Circle any current problems you are having:

- | | | | |
|-----------|---------------------|-------------------|------------------|
| headaches | shortness of breath | visual problems | hearing problems |
| cough | ringing in the ears | coughing up blood | abdominal pain |
| Fatigue | diarrhea | nausea | vomiting |

Hospitalizations: _____

Surgeries: _____

| Have you had any of the following? | Vaccine? List Date | Disease? List date |
|------------------------------------|-----------------------|-----------------------|
| Chicken Pox | | |
| Hepatitis A | | |
| Hepatitis B | | |
| Polio | | |
| Rabies | | |
| Smallpox | | |
| Typhoid | | |

| Have you had any of the following? | Vaccine? List Date | Disease? List date |
|-------------------------------------|-----------------------|-----------------------|
| Influenza (flu) vaccine | | |
| Japanese Encephalitis vaccine | | |
| Meningococcus | | |
| Tetanus booster, w/wo diptheria | | |
| Tetanus, Diptheria, Pertusis (TDAP) | | |
| Mumps, Measles, Rubella (MMR) | | |
| Yellow Fever | | |

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COVID SCREENING

- *Are you Currently covid+ & under home isolation? YES OR NO
- *Fever of 100.00 or higher or chills? YES OR NO
- *Dry or persistent cough? YES OR NO
- *Shortness of Breath? YES OR NO
- *Loss of taste or smell? YES OR NO

Last 14 days, close contact (within 6 feet for 15 min or longer) with:

- *Anyone covid positive? YES OR NO
- *Or anyone who has symptoms of covid? YES OR NO



Consent, Assignment of Benefits & Financial Agreement

Consent to Diagnostic Tests, Medical Treatment and Procedures:

I do voluntarily consent to care involving diagnostic tests, medical treatment and procedures by the physicians/practitioners of Commonwealth Health Corporation, d/b/a Infectious Disease and Travel Medicine Specialists, their assistants and designees, and other employees of Infectious Disease and Travel Medicine Specialists as is necessary or advisable in their judgment. This consent includes testing for communicable diseases, including but not limited to Human Immunodeficiency Virus (HIV), hepatitis or any other blood-borne infectious disease if ordered for a diagnostic purpose or due to occupational exposure of a health care worker. I acknowledge no guarantee has been made to me as to the results of examination and treatment.

Assignment of Benefits and Financial Agreement:

I certify all information given by me is correct and I accept responsibility for the charges for the care provided. I agree to the assignment of all third-party benefits to Infectious Disease and Travel Medicine Specialists and to any physician, practitioner, organization or independent contractor who provided products or services, and agree to pay all charges not covered by third-party payers. If I am covered by an ERISA plan, with this assignment I specifically authorize my providers to receive copies of all notifications and information that I am legally entitled to receive under the terms of my insurance/health plan and to act on my behalf to appeal benefit determinations. I acknowledge any claim for benefits from a third party payer may be filed by Infectious Disease and Travel Medicine Specialists as a courtesy to me. However, I am primarily responsible for monitoring the filing process and making certain the claim is filed in compliance with the provisions specified by the applicable third party payer. The filing of the claim by Infectious Disease and Travel Medicine Specialists in no way releases me from liability for any portion of the bill not paid by a third party payer for any reason.

Unless other payment arrangements are approved by Infectious Disease and Travel Medicine Specialists, the account balance is due upon demand. Failure to pay for the services may result in the placement of an account with a collection agency or attorney for collection. All amounts due, as shown in the final statement and/or amended final statement, shall bear interest from the due date until paid at a per annum rate of eight percent (8%). In the event there is a judgment, the amount due shall accrue interest at the judgment rate of six percent (6%) until paid in full. Further, I agree to pay all costs of collection including court costs, interest, attorney fees and collection agency fees.

Contact Information:

I agree Infectious Disease and Travel Medicine Specialists, Commonwealth Health Corporation and their agents, attorneys or collection agencies may contact me regarding medical information or information about my account or for the purposes of collection by telephone at any number provided by me including wireless telephone numbers, and via text messaging or e-mail to any e-mail address provided. Methods of contact may include the use of pre-recorded or artificial voice messages and/or automated dialing.

Release of Information:

I authorize the release of all or part of my records, including information stored in Infectious Disease and Travel Medicine Specialists' corporate-wide database, to my physician(s), whose name I provided at the time of registration, and to any physician or practitioner who has or will provide services to me. I authorize the release of statistical information as required by any local, state or federal agency or managed care program. I authorize the release of my HIV test results to health care personnel in the event of an occupational exposure.

I authorize Infectious Disease and Travel Medicine Specialists and any other holder of medical or other information to release information about me (including medical information concerning psychological or psychiatric conditions, alcoholism and/or drug related conditions and HIV or other blood-borne infectious diseases) as required to complete any claim for benefits due to services rendered to me to any person or corporation which is or may be responsible for all or part of the total charge incurred. The persons or corporations to which this information may be released includes, but is not limited to insurance companies, the Social Security Administration, its intermediaries and carriers, state agencies and workers' compensation carriers, as well as the review organization employed by my employer or the employer of the insured member of my family and any corporation engaged by Infectious Disease and Travel Medicine Specialists to make collection of any unpaid charges. I further authorize my employer to release to Infectious Disease and Travel Medicine Specialists or any agency engaged for the purpose of collecting any unpaid charges, verification of my employment status, including the amount of salary or wages and the number of hours worked.

Information Received:

I acknowledge receipt of the NOTICE OF PRIVACY (initial) PRACTICES.

This authorization is valid until revoked in writing. (initial)

My medical/financial information may also be released to the following persons. (initial)

Primary Care Physician: _____

If you were sent to us by another physician, please list the physician: _____

Print patient name: _____

Signature Date Time Relationship (if not patient)

Witness

ADULT IMMUNIZATION:

Importance of Staying Up to Date with Vaccines

And here are several reasons why...

► **Vaccines aren't just for kids.**

Vaccines are recommended throughout people's lives.

► **Adults are at risk.**

Most illnesses, hospitalizations, disability, and deaths from vaccine-preventable diseases occur among adults.

► **Many adults aren't up to date with their vaccinations.**

Most adults are not aware of the many vaccines recommended for them. In fact, only about 1 in 5 adults is actually up to date, leaving many adults vulnerable.

► **Adults need more than an annual influenza vaccination.**

Although most adults know they are recommended to receive influenza vaccine each year, they may not be aware of other vaccines that might be recommended for them to prevent tetanus, diphtheria, pertussis (whooping cough), pneumococcal disease, shingles, hepatitis A and B, meningococcal disease, measles, mumps, rubella, and human papillomavirus.

► **Vaccines help adults stay healthy and able to meet their many obligations.**

Adults need to stay healthy so that they can work, take care of their families and themselves, and fulfill other commitments in their lives.

► **Vaccines protect loved ones.**

Vaccines can help prevent adults from spreading a severe illness to a loved one. For example, getting vaccinated against pertussis can help protect new babies in the family from this serious disease. And, influenza vaccination reduces the risk of spreading illness to family members like infants and elderly people who may be more vulnerable to severe complications associated with influenza.

► **Vaccines protect pregnant women and their babies.**

Pregnant women who get Tdap and influenza vaccine during pregnancy protect themselves and their babies from influenza and pertussis (whooping cough), influenza-related preterm labor in moms, and hospitalizations for their babies.

► **Vaccines prevent serious health-related complications from vaccine-preventable illnesses.**

Vaccines can also prevent complications of infections that sometimes occur with a vaccine-preventable disease, such as damage to the eye from shingles or heart attacks brought on by influenza illness.

► **Vaccines reduce risks related to other health conditions.**

Adults need vaccinations based on their age and health conditions. Some health conditions, including diabetes, heart disease, and lung disease, increase a person's risk of severe illness from vaccine-preventable infections.

► **Vaccines help ensure adults stay healthy during travel.**

Getting sick while traveling can ruin plans and be costly. Adults should discuss any upcoming travel plans with their providers to make sure they are appropriately vaccinated prior to departure.

For more information on vaccines for adults, talk to your healthcare provider and pharmacist. Additional information is available at Immunization Action Coalition at www.vaccineinformation.org/adults and the Centers for Disease Control and Prevention at www.cdc.gov/vaccines/adults/index.html