ATLANTA TRAVEL MEDICINE

Travel Patient Registration

* **Date**: _____ * (Required field)

* **Name**: _____ * **Date of Birth**: _____

New or Established Travel Patient? ○ New ○ Established

Has any of the Registration information below changed? ○ Yes ○ No

Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____ Age: _____ Sex: ○ M ○ F

_____ Work Phone: _____ Marital Status: _____

City: _____ Cell Phone: _____ Emerg. Contact: _____

State: _____ Zip Code: _____ Email: _____ Relationship: _____

Employer: _____ Occupation: _____ Emerg. Phone: _____

Travel Plan

Type of Travel: ☐ Business ☐ Tourist ☐ Student ☐ Mission

Will you have access to medical care if necessary? _____

Destination(s) of Travel (include dates of arrival and departure for each country and rural travel expected for each)

Destination	Arrival Date	Departure Date	Rural Travel?
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No

Your consultation fee plus approximate cost of vaccinations and medications are discussed with you prior to any treatment. You will receive an itemized record of services and an itemized copy of your bill at check out. **(Atlanta Travel Medicine does not participate with any insurance companies and does not assist with insurance filing.)**

Payment is due in full at time of service. Visa, MasterCard, American Express and Discover, as well as in-state checks and cash payments are accepted.

How did you learn about us? ☐ Physician ☐ Friend/Family ☐ Google ☐ Employer: _____

☐ Other (please list) _____

_____

Signature

_____ _____

Signature (Parent /Guardian of Minor) Date

Please bring any immunization records you may have to your visit.

Please submit this form before your visit.

Print Clear

Save Submit

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