aitc IMMUNIZATION & TRAVEL CLINIC
SF DEPARTMENT OF PUBLIC HEALTH

Adult Immunization & Travel Clinic
101 Grove Street, Room 102
San Francisco, CA 94102
ph (415) 554-2625 fx (415) 554-2619
www.sfdph.org/aitc

PLEASE PRINT CLEARLY

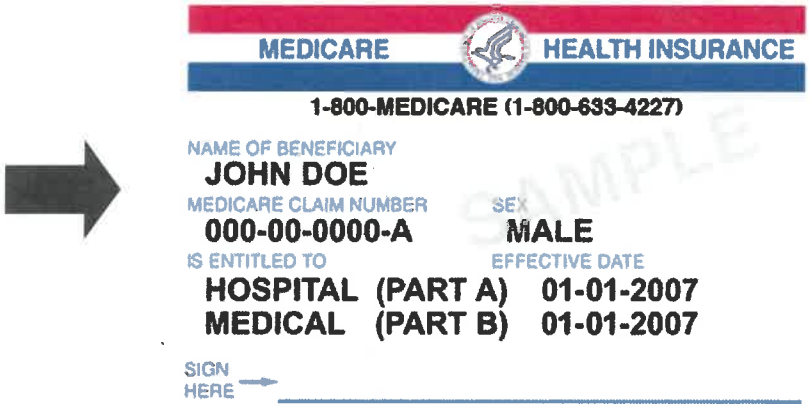
NAME _____

BIRTHDATE _____

SIGNATURE _____

TODAY'S DATE _____

The Medicare card (federal government issued health insurance) looks exactly like this



PLESE CHECK ONE:

☐ **NO**, I am **NOT** enrolled in any type of Medicare Plan

☐ **YES**, I have Medicare (read below)

Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

FOR STAFF ONLY:
☐ Contracts on file

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TO OUR VALUED **MEDICARE** CLIENTS:

- Our Medical Director and Nurse Practitioner have "opted out" of Medicare
- To receive services at AITC, please sign and date both of the attached Private Contracts, one with our Medical Director and one with our Nurse Practitioner
- This contract is with AITC Immunization & Travel Clinic only. It does not affect your Medicare benefits anywhere else
- Unfortunately, if you do not sign a Private Contract with AITC, we will not be able to provide services to you

What signing the Private Contract means:

- To receive services at AITC, you must pay out-of-pocket at our listed prices, even if those services would be covered elsewhere by Medicare
- Medicare will not pay for any services received at AITC
- You agree not to submit a claim to Medicare
- AITC will not bill Medicare for you
- You are not required to sign a Private Contract with AITC. You are free to seek Medicare services elsewhere from a practitioner that has not opted-out

- THANK YOU FOR YOUR UNDERSTANDING

Client Registration Form

IMMUNIZATION & TRAVEL CLINIC

(Please Print Clearly)

Last Name

First Name **M.I**

Birthdate M M D D Y Y

Race/Ethnicity
- ☐ White
- ☐ African-Amer.
- ☐ Asian
- ☐ Hispanic/Latino
- ☐ Other

What was your sex at birth?
- ☐ Male ☐ Female

What is your gender identity?
- ☐ Male ☐ Female
- ☐ Trans Male ☐ Trans Female
- ☐ Genderqueer / Gender non-binary
- ☐ If Not Listed, please specify below

_____

Email

PHONE: CELL ( ) _____-_____ ☐**HOME** ☐**OFFICE : ( ) _____-_____**

ADDRESS: _____
City State Zip

OCCUPATION: _____ **EMPLOYER/SCHOOL:** _____

WORK/SCHOOL ADDRESS: _____

EMERGENCY CONTACT _____
Name Relationship Phone

HOW DID YOU LEARN ABOUT AITC: (CHECK ALL THAT APPLY)

☐ I am an established client of AITC ☐ Web Search ☐ Yelp ☐ Referral by my friend/family/school/ work ☐ Other

☐ Referral by my doctor/clinic (name, phone) _____

Consent for Medical Care and Payment Responsibility

(1) I, as the client/patient, agree to receive care from a health care Provider at the Adult Immunization & Travel Clinic ("AITC"), San Francisco Department of Public Health ("DPH"). I give consent for examination, immunization, blood or skin testing, medical advice, and other services from my AITC Provider.

(2) If my AITC Provider prescribes a drug, I understand that AITC can transmit the prescription to a pharmacy of my choice; or, if I purchase the drug from AITC, I understand that the drug is not returnable and that insurance may not reimburse the cost.

(3) I have reviewed the information about privacy practices and disclosures on the reverse side of this form.

(4) I understand that AITC is not a Medicare provider.

(5) I understand and agree that: (a) it is my responsibility to pay the charges in full for all services rendered; (b) I authorize my insurance company to pay directly to AITC any benefits due under the terms of my health care plan for services provided by AITC; (c) AITC reserves the right to refuse assignment of medical benefits; and (d) if my insurance company does not pay the charges in full, it is my responsibility to pay the entire full balance for all services rendered by AITC.

Signed: _____ **Date:** _____

If client is a minor:

Print name of parent/ guardian: _____

Signature of parent/guardian: _____ Date: _____

SFDPH SUMMARY NOTICE OF HIPAA PRIVACY PRACTICES

Full Notice: You have been provided the Full Notice of HIPAA Privacy Practices. Please read it carefully. You can also find it at: https://www.sfdph.org/dph/comupg/oservices/medSvs/HIPAA/HIPAASummaries.asp.

Who will follow the rules in this notice: All DPH and contract provider employees, DPH affiliates, as well as staff assigned to DPH by the University of California at San Francisco, must follow these rules.

You have the right to: (Please see possible restrictions in the "Full Notice of Privacy Practices".)

- Ask to see, read and/or obtain a copy of your health record (charges may be necessary).
- Ask to correct information that you believe is wrong in your health record.
- Ask that your health information not be shared with certain individuals.
- Ask that your health information not be used for certain purposes; for example, research.
- Ask that copies of your health record be sent to someone (charges may be necessary).
- Be informed about who has read your record (for reasons other than treatment, payment and program improvement purposes).
- Specify where and how DPH employees may contact you.

DPH may use and disclose your health information to improve your treatment.

- To improve the quality of care you receive, health information may be shared between treatment providers, including your health information regarding mental health, substance abuse, HIV/AIDS, sexually transmitted diseases (STD), and developmental disabilities.
- There are circumstances when health information about you will not be shared unless you first give your permission for it to be shared; such as services received in substance abuse treatment agencies.

If you believe your privacy rights have NOT been maintained while receiving DPH services, you may file a complaint. If you have concerns about how your health information might be (or has been) shared, please speak with your provider or contact either of the following: (1) Secretary of U.S. Dept. of Health and Human Services, Office of Civil Rights, Attn: Regional Manager, 50 United Nations Plaza, Rm. 322, San Francisco, CA 94103. (2) DPH Office of Compliance and Privacy Affairs, 101 Grove St., Room 330, San Francisco, CA 94102, or call toll-free 1-855-729-6040. You will not be penalized in any way for filing a complaint.

By your signature on the reverse side of this page, you:

- Acknowledge receipt of the San Francisco Department of Public Health "Full Notice of HIPAA Privacy Practices."
- Agree that if the DPH services you received at AITC are to be billed to a third party health insurance, then you authorize the release to the insurer, the claims processor, and their intermediaries, of any medical and other information necessary to process the claim.

July 2017

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CONFIDENTIAL MEDICAL HISTORY FORM *(page 1 of 2)*

NAME: _____
BIRTHDATE: _____

⇨ REASON(S) FOR YOUR VISIT TODAY

- ☐ Exposed to a **contagious disease**. Which? _____
- ☐ Planning **International Travel**
- ☐ **Blood test.** Which? _____
- ☐ **TB test** (tuberculosis)
- ☐ **Vaccination** (Reason) _____
  (Which vaccine(s)? _____
- ☐ Other. State reason _____

⇨ YOUR ALLERGIES

☐ **No Allergies**

I am allergic to:

☐Latex	☐Thimerosal	☐Fish	☐Eggs
☐Neomycin	☐Sulfa drugs	☐Shellfish	☐Chicken
☐Streptomycin	☐Penicillin	☐Bee stings	☐Nuts

PLEASE LIST ANY **OTHER** ALLERGIES:

⇨ MEDICINES YOU ARE TAKING NOW

List **all prescription and non-prescription drugs** you take regularly or occasionally.

⇨ YOUR MEDICAL CONDITIONS

Have you **ever** had ...

weakened immunity or **HIV**?	☐ No	☐ Yes
treatment for **cancer**?	☐ No	☐ Yes
seizures or **epilepsy**?	☐ No	☐ Yes
trouble with your **thymus** (not thyroid)..	☐ No	☐ Yes
trouble with your **spleen**?	☐ No	☐ Yes
liver or **kidney** disease?	☐ No	☐ Yes
heart or **lung** disease?	☐ No	☐ Yes
depression or **anxiety**?	☐ No	☐ Yes
another **psychological** condition?	☐ No	☐ Yes
Smoked **cigarettes** in the past 10 years?	☐ No	☐ Yes
Any **other medical conditions** you have or are being treated for now?	☐ No	☐ Yes

IF **YES** TO ANY OF THE ABOVE, PLEASE DESCRIBE:

⇨ HAVE YOU EVER ...

Fainted or felt light-headed after a shot?	☐ No	☐ Yes
- Or after a blood test or other needle?	☐ No	☐ Yes
Had any unusual reaction to a vaccine?	☐ No	☐ Yes

IF **YES** TO ANY OF THE ABOVE, PLEASE DESCRIBE:

_____

What meal(s) have you eaten so far today?

☐ Breakfast ☐ Lunch ☐ Snack ☐ Nothing

⇨ TELL US ABOUT YOUR PAST VACCINATIONS

Did you have all your childhood vaccinations? ☐ No ☐ Yes ☐ Not sure

Did you attend college or university in the USA? ☐ No ☐ Yes ➔ during what years? _____

Where were you born? ☐ USA ☐ Other Country ➔ _____

If you were born outside the USA:

- At what age did you arrive in the USA? _____
- Did you get vaccines for immigration? ☐ No ☐ Yes ☐ Not sure

⇨ FEMALES ONLY

Are you pregnant now? ☐ No ☐ Yes ☐ Maybe

Are you breastfeeding now? ☐ No ☐ Yes

Contraception/Birth control method(s): ☐ Birth Control Pill ☐ Condoms ☐ IUD ☐ Implant ☐ NuvaRing ☐ Rhythm ☐ NONE

- If NONE, please check all that apply: ☐ Not sexually active ☐ No sex with men ☐ Partner vasectomy ☐ Tubal Ligation ☐ Hysterectomy ☐ Other _____

Are you planning to become pregnant soon? ☐ No ☐ Yes ➔ When? _____

When did your last menstrual period start? (Date) _____ ☐ I do not have menstrual periods

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CONFIDENTIAL MEDICAL HISTORY FORM *(page 2 of 2)*

⇨ HELP US UNDERSTAND YOUR VIRAL HEPATITIS RISK

Have you had a blood test for Hepatitis B or Hepatitis C infection? ☐ No ☐ Yes ☐ Not sure Result: _____

Have you ever been told you could not donate blood? ☐ No ☐ Yes

Have you donated blood in the last 5 years? ☐ No ☐ Yes

➔ ***To help determine your risk of past infection with Hepatitis B or C: Please check all that apply.***

These first 3 questions refer to Asia, Pacific Islands, Middle East, Africa, Eastern Europe, or the Amazon area of South America:

☐ I was born there ☐ One or both of my parents was born there

☐ I spent at least 6 months in _____, or had sexual contact with local people there

☐ I received a blood transfusion in the USA (before 1992) or in another country (anytime)

☐ My tattoo, piercing, or acupuncture could have been done with unsterile (dirty) equipment

☐ I had contact with human blood or body fluids at work

☐ I had a sex partner who had Hepatitis B or C

☐ I exchanged money or drugs for sex

☐ I had unprotected sex with a non-monogamous partner

☐ I was born during 1945—1965

☐ I lived with someone who had Hepatitis B or C

☐ I am a male who has had sex with other males

☐ I had a sexually transmitted disease

☐ I injected street drugs

☐ I am Native American or Alaskan Native

☐ **One or more of the above statements apply to me — but I prefer not to say which one(s)**

☐ **None of the above statements apply to me**

⇨ IF PLANNING INTERNATIONAL TRAVEL, PLEASE ANSWER THE FOLLOWING AS COMPLETELY AS YOU CAN:

Departure Date: _____

Return Date: _____

Purpose of Trip *(check all that apply):*

☐ Pleasure or Vacation ☐ Study abroad

☐ Business *(type)*_____

☐ Moving or relocating to live abroad

☐ Visiting my homeland

☐ Volunteer/Missionary/Humanitarian

☐ Other _____

Activities *(check all that apply):*

☐ Camping

☐ Hiking or trekking

☐ Bicycling or motorcycling

☐ Caving

☐ High altitude >8000 ft.

☐ Work with animals

☐ Work at orphanage

☐ Cruise ship

☐ Visit jungle area

☐ Visit rural area or village

☐ Visit farm

☐ SCUBA dive

☐ Other _____

Please List Each Country You Will Visit List in the order you will be visiting them Include all stopovers	**How Long in the Country**	**Type of Accommodations** (e.g. hotel, resort, hostel, tent, apt, home stay)
	☐days ☐wks	
	☐days ☐wks	
	☐days ☐wks	
	☐days ☐wks	
	☐days ☐wks	
	☐days ☐wks	
	☐days ☐wks	

⇨ PLEASE SIGN HERE

I certify that the above information is correct to the best of my knowledge. I will not hold this clinic or its staff responsible for any errors or omissions that I may have made in completing this form.

_____ _____

SIGNATURE OF CLIENT (OR PARENT/GUARDIAN) TODAY'S DATE

_____

PRINT NAME OF CLIENT (OR PARENT/GUARDIAN)

NAME:_____ **BIRTHDATE:**_____

STOP! Below are for AITC staff only

HISTORICAL				TODAY'S VISIT							
# doses	Date of Last				Dis	Rec	Dec	Def	Ser #	Site	Lot #
			Cholera		☐	☐	☐	☐			
		☐+Dz | Serol ☐+ ☐-	Hep A		☐	☐	☐	☐			
		☐+Dz | Serol ☐+ ☐-	Hep B		☐	☐	☐	☐			
			Twinrix		☐	☐	☐	☐			
		☐Gardsl ☐Cervarx	HPV	☐Gardasil	☐	☐	☐	☐			
			Influenza	☐Inj ☐Pfree ☐FluMist	☐	☐	☐	☐			
		☐JE Vax ☐Ixiaro	JE	☐Ixiaro	☐	☐	☐	☐			
		☐ Menomu ☐ Menact ☐ Menveo	MenACWY	☐ Menactra ☐ Menveo	☐	☐	☐	☐			
		☐ Bexsero ☐Trumen	MenB	☐ Bexsero	☐	☐	☐	☐			
			MMR		☐	☐	☐	☐			
		☐+Dz | Serol ☐+ ☐-	Measles		☐	☐	☐	☐			
		☐+Dz | Serol ☐+ ☐-	Mumps		☐	☐	☐	☐			
		☐+Dz | Serol ☐+ ☐-	Rubella		☐	☐	☐	☐			
			Pneumovax23		☐	☐	☐	☐			
			Prevnar13		☐	☐	☐	☐			
			PPD		☐	☐	☐	☐			
			Polio		☐	☐	☐	☐			
			Rabies	☐Imovax ☐Rabavert	☐	☐	☐	☐			
		☐Td ☐Tdap	Tetanus	☐Adacl ☐Td ☐Boostx	☐	☐	☐	☐			
		☐injectable ☐ oral	Typhoid	☐Typhim ☐Vivovif	☐	☐	☐	☐			
		☐+Dz | Serol ☐+ ☐-	Varicella		☐	☐	☐	☐			
			Yellow Fever		☐	☐	☐	☐			
			Zostavax		☐	☐	☐	☐			

Hep RISK ASSESSMENT	
Prior Risk Factor(s)	☐HBV ☐HCV ☐Neither ☐Unsure
Prior Testing	☐HBV ☐HCV ☐Neither ☐Unsure
HBV Test Result (if done)	☐Infected ☐Immune ☐Susceptible ☐Unsure
HBV Vax Series Completed ***Before*** Risk Began?	☐No ☐Yes ☐Unsure ☐N/A
HBV Panel Recommended?	☐No ☐Yes
HCV Ab Test Recommended?	☐No ☐Yes

RX	Dis	Rec	Dec	Def	Ordered
Malaria Prophylaxis	☐	☐	☐	☐	☐Malarone ☐Doxycycline ☐Chloroq ☐ Mefloquine
Travelers' Diarrhea	☐	☐	☐	☐	☐Cipro ☐Azithro ☐Rifaximin ☐Tinidazole
Altitude	☐	☐	☐	☐	☐Acetazolamide
Anaphylaxis	☐	☐	☐	☐	☐Epi-Pen
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

BLOOD TESTS	Dis	Rec	Dec	Def	Ordered
Measles IgG	☐	☐	☐	☐	☐
Mumps IgG	☐	☐	☐	☐	☐
Rubella IgG	☐	☐	☐	☐	☐
VZV IgG	☐	☐	☐	☐	☐
HAV Antibody	☐	☐	☐	☐	☐
HBs Antibody	☐	☐	☐	☐	☐
HBs Antigen	☐	☐	☐	☐	☐
HBc Antibody	☐	☐	☐	☐	☐
HCV Antibody	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

COUNSELING	
Food/Water Precautions	☐
Travelers' Diarrhea Management	☐
Insect/Mosquito Precautions	☐
Altitude Precautions	☐
Animal Bite/Rabies Precautions	☐

Additional Comments:

AITC Provider Signature: Date:

Travel Health Visit Appointment Check List

__ Please arrive 20min before your appointment time

__ Please arrive on time with this packet completed

__ Please bring your immunization records

__ If you are driving make sure to arrive EXTRA early to find parking. There are frequent street closures.

__ Make sure to eat a full meal before you come and be well hydrated when you arrive.

We are located only 10mins away from
Civic Center Muni/BART station.

With respect to other patients' time, all late arrivals are subject to be rescheduled.
All forms need to be completed and all adult patients need to be present at the start of your appointment time.
Thank you for your understanding.