**IMMUNIZATION & TRAVEL CLINIC**

101 Grove Street, Room 102
San Francisco, CA 94102
Ph (415) 554-2625 Fax (415) 554-2619
www.sfdph.org/aitc

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**PLEASE PRINT CLEARLY**

**NAME**

**BIRTHDATE**

**SIGNATURE**

**TODAY'S DATE**

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

![Medicare Card Example]

**PLEASE 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).

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**FOR STAFF ONLY:**

- [ ] Contracts on file
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

(Please Print Clearly)

Last Name

First Name

Birthdate

What was your sex at birth?

What is your gender identity?

ONLY FOR 18 AND OLDER:
How do you describe your sexual orientation or sexual identity?

Race/Ethnicity

Phone:  

Mail:  

Occupation:

Emergency Contact

How Did You Learn About AITC: (Check all that apply)

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.

Signature of Patient/Parent/Legal Guardian or Representative

Date

Print name of Patient/Parent/Legal Guardian or Representative

Specify relationship

Interpreter if applicable

Version 3 Sept 2020
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.

Notice Regarding Unsecure Data Transmission by Email: DPH email does not provide secure data transmission as defined by HIPAA. Therefore DPH email transmission may not be secure against unauthorized disclosure.

By your signature on the reverse side of this page, you:
- Acknowledge receipt of the San Francisco Department of Public Health "Notice of Privacy Practices."
- Acknowledge that DPH email may not be secure against unauthorized disclosure, and agree that DPH may send your health information to you via unsecure email, but only upon your specific request to receive such information by email.
- Agree that if the DPH services you received at AITC are to be billed to a third party, then your name, the services to be paid by the third party, and other information necessary to complete the billing, may be disclosed to the third party payor.

STAFF/WITNESS: If written acknowledgement is NOT obtained, please complete the following:

☐ Unable to sign ☐ Declined to sign ☐ Other, Describe:

<table>
<thead>
<tr>
<th>SIGNATURE OF STAFF WITNESS</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRINT NAME</td>
<td>DEPARTMENT/ORG</td>
</tr>
</tbody>
</table>

5/22/15
**CONFIDENTIAL MEDICAL HISTORY FORM**  
*(page 1 of 3)*

### A. REASON FOR YOUR VISIT TODAY
- Planning International Travel
- Vaccination (Reason)
- TB test (tuberculosis)
- Blood test. Which?
- Exposed to a contagious disease. Which?
- Other (State reason)

### B. YOUR ALLERGIES
- Latex
- Thimerosal
- Fish
- Eggs
- Neomycin
- Sulfur drugs
- Shellfish
- Chicken
- Streptomycin
- Penicillin
- Bee stings
- Nuts
- Feathers

**PLEASE LIST ANY OTHER ALLERGIES**

**☐ No Allergies**

### C. MEDICATIONS YOU TAKE NOW
List all medications you take regularly or occasionally. Attach a list if you have one.

**Prescription** __________  **Non-Prescription** __________

**☐ No Medications**

### D. PAST VACCINATIONS
- Had all your childhood vaccinations?  
  - Yes  
  - No  
  - Not sure
- Country of birth: __________________________
- If you were born outside the USA:
  - At what age did you arrive in the USA? __________________________
  - Had vaccines for immigration?  
    - Yes  
    - No  
    - Not sure
- Attended college or university in the USA?  
  - Yes  
  - No  
  - Not sure
- If yes, during what years? __________________________

### E. WHAT MEALS HAVE YOU EATEN SO FAR TODAY?
- Breakfast  
- Lunch  
- Snack  
- Nothing

### F. YOUR MEDICAL CONDITIONS
**Have you ever had ...**
- weakened or suppressed immunity?  
  - No  
  - Yes
- HIV infection?  
  - 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
- G6PD deficiency?  
  - No  
  - Yes

**Smoked cigarettes in the past 10 years?  
  - Yes**

Any other medical conditions you have or are being treated for now? __________________________

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

### G. JUST FOR FEMALES / THOSE WITH A UTERUS
- Pregnant now?  
  - No  
  - Yes  
  - Maybe
- Breastfeeding now?  
  - No  
  - Yes
- Planning to become pregnant soon?  
  - No  
  - Yes
  - If yes, when? __________________________
- Start of your last normal menstrual period  
  - (Date) __________________________ or ☐ I do not have periods

**Contraception / Birth control method you use:**
- Birth Control Pill  
- Condoms  
- IUD  
- Implant
- NuvaRing  
- Rhythm  
- NONE

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

### H. 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, describe __________________________

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*Please turn over to Page 2 →*
I. PAST HEPATITIS TESTING ...
- Ever been tested for Hepatitis B infection? □ No □ Yes □ Not sure - if yes, result: ________________________
- Ever been tested for Hepatitis C infection? □ No □ Yes □ Not sure - if yes, result: ________________________
- Ever been told you could not donate blood? □ No □ Yes
- Have you donated blood in the last 5 years? □ No □ Yes

J. HEPATITIS B OR C RISK
- One or more of the statements below apply to me — but I prefer not to say which one(s)
  □ None of the statements below apply to me
  □ I am a male who has had sex with other males B,C
  □ One or both of my parents was born in sub-Saharan Africa B
  □ I was born in or spent > 6 months living in a developing country B
  □ I have lived with someone who had Hepatitis B B
  □ I received a blood transfusion in the USA (before 1992) or in another country (anytime) C
  □ My hemophilia was treated with clotting factor concentrates before 1987 C
  □ My tattoo, piercing, or acupuncture could have been done with unsterile (dirty) equipment C

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

<table>
<thead>
<tr>
<th>Departure Date:</th>
<th>Purpose of Trip (check all that apply):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Pleasure or Vacation □ Study abroad</td>
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<td></td>
<td>□ Business (type)</td>
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<tr>
<td></td>
<td>□ Moving or relocating to live abroad</td>
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<tr>
<td></td>
<td>□ Visiting my homeland</td>
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<td></td>
<td>□ Volunteer/Missionary/Humanitarian</td>
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<td></td>
<td>□ Other</td>
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</table>

<table>
<thead>
<tr>
<th>Return Date:</th>
<th>Activities (check all that apply):</th>
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<tbody>
<tr>
<td></td>
<td>□ Work at orphanage</td>
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<tr>
<td></td>
<td>□ Cruise ship</td>
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<td></td>
<td>□ Visit jungle area</td>
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<td>□ Visit rural area or village</td>
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<td>□ Visit farm</td>
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<tr>
<td></td>
<td>□ SCUBA dive</td>
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<td>□ Other</td>
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Please List Each Country You Will Visit
List in the order you will be visiting them Include all stopovers

<table>
<thead>
<tr>
<th>How Long in the Country</th>
<th>Type of Accommodations (e.g. hotel, resort, hostel, tent, apt, home stay)</th>
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<tbody>
<tr>
<td>□ days □ wks</td>
<td>□ Work at orphanage</td>
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<tr>
<td>□ days □ wks</td>
<td>□ Cruise ship</td>
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<tr>
<td>□ days □ wks</td>
<td>□ Visit jungle area</td>
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<tr>
<td>□ days □ wks</td>
<td>□ Visit rural area or village</td>
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<tr>
<td>□ days □ wks</td>
<td>□ Visit farm</td>
</tr>
<tr>
<td>□ days □ wks</td>
<td>□ SCUBA dive</td>
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<tr>
<td>□ days □ wks</td>
<td>□ Other</td>
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L. PLEASE SIGN AND PRINT YOUR NAME BELOW

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 _______________________________
### HISTORICAL

<table>
<thead>
<tr>
<th># doses</th>
<th>Date of Last Visit</th>
<th>Date of Test</th>
<th>Hepatitis A</th>
<th>Hepatitis B</th>
<th>Influenza</th>
<th>Varicella</th>
<th>Yellow Fever</th>
<th>Rabies</th>
<th>DTd</th>
<th>Tdap</th>
<th>Tetanus</th>
<th>Pertussis</th>
<th>Pneumovax 23</th>
<th>Prevnar 13</th>
<th>DT</th>
<th>DTa</th>
<th>DTb</th>
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**Hepatitis Risk Assessment**

- Prior Risk Factors: Unknown/No Risk
- Prior Testing: Unknown/No Risk
- HBV Test Result (if done): Unknown/No Risk
- HBV Panel Recommended?: Unknown/No Risk
- HCV Ab Test Recommended?: Unknown/No Risk

**Blood Tests**

<table>
<thead>
<tr>
<th>Test</th>
<th>HBsAg</th>
<th>Anti-HBc</th>
<th>Anti-HBs</th>
<th>Anti-HBe</th>
<th>Anti-HDc</th>
<th>Anti-HDV</th>
<th>HCV Ab</th>
<th>HAV Ab</th>
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**Medications**

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**Additional Comments:**

AITC Clinician Signature: ___________________________

Date: ___________________________