Registration Packet

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

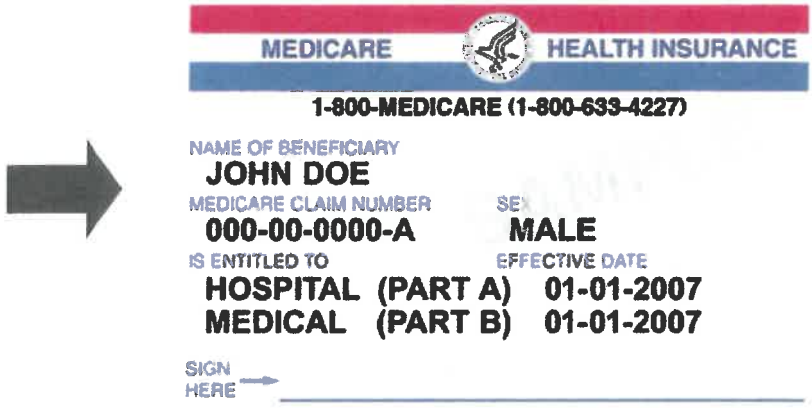
NAME _____

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

aitc IMMUNIZATION & TRAVEL CLINIC
SF DEPARTMENT OF PUBLIC HEALTH

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)

IMMUNIZATION & TRAVEL CLINIC
SF DEPARTMENT OF PUBLIC HEALTH

Legal Last Name

Legal First Name **M.I**

☐ I have a different legal name _____

Birthdate M M D D Y Y

Race
☐ African-Amer.
☐ American Indian (Native)
☐ Asian
☐ Other
☐ Pacific Islander
☐ White

What was your sex at birth?
☐ Male ☐ Female

Ethnicity
☐ Hispanic/Latino
☐ Non Hispanic
☐ Unknown

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

ONLY FOR 18 AND OLDER: How do you describe your sexual
☐ Bisexual
☐ Gay/Lesbian/Same-gender loving
☐ Straight/Heterosexual
☐ Questioning/Unsure
☐ Not listed: _____
☐ Decline to state

Email Address

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

MAILING ADDRESS _____
APT# City State Zip

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

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.

Nov 2019

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CONFIDENTIAL MEDICAL HISTORY FORM *(page 1 of 3*

NAME:

BIRTHDATE:

A. Reason for Your Visit Today

☐ Planning **International Travel**

☐ **Vaccination** (Reason)_____

Which vaccine(s)? _____

☐ **TB test** (tuberculosis)

☐ **Blood test.** Which? _____

☐ Exposed to a **contagious disease**. Which? _____

☐ Other (State reason) _____

B. Your Allergies

☐Latex	☐Thimerosal	☐Fish	☐Eggs
☐Neomycin	☐Sulfa 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? ☐ No ☐ Yes ☐ 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? ☐ No ☐ Yes ☐ Not sure
- Attended college or university in the USA? ☐ No ☐ Yes
  - 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? ..... ☐ 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:

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 _____

Please turn over to Page 2 ➡

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CONFIDENTIAL MEDICAL HISTORY FORM *(page 2 of 3)*

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 or had a sex partner 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]

☐ I was born during 1945—1965 [C]

☐ I have HIV infection [B,C]

☐ I have injected street drugs [B,C]

K. 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	

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

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CONFIDENTIAL MEDICAL HISTORY FORM *(page 3 of 3)*

NAME: _____

BIRTHDATE:

***** STOP ! PLEASE LEAVE THE AREA BELOW BLANK—AITC Staff will complete *****

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		☐	☐	☐	☐			
			Hib		☐	☐	☐	☐			
		☐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		☐	☐	☐	☐			
			Polio		☐	☐	☐	☐			
			Rabies	☐Imovax ☐Rabavert	☐	☐	☐	☐			
		☐Td ☐Tdap	Tetanus	☐Adacl ☐Td ☐Boostrx	☐	☐	☐	☐			
		☐injectable ☐ oral	Typhoid	☐Typhim ☐Vivovif	☐	☐	☐	☐			
		☐+Dz | Serol ☐+ ☐-	Varicella		☐	☐	☐	☐			
			Yellow Fever	☐Stamaril ☐YF-Vax	☐	☐	☐	☐			
		☐Zostavax	Shingrix		☐	☐	☐	☐			

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

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	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

RX	Dis	Rec	Dec	Def	Ordered
Malaria Prophylaxis	☐	☐	☐	☐	☐ MAL ☐Doxy ☐CQ ☐MQ ☐ PQ ☐ TQ
Travelers' Diarrhea	☐	☐	☐	☐	☐Cipro ☐Azithro ☐Rifaximin ☐Tinidazole
Altitude	☐	☐	☐	☐	☐Acetazolamide
Anaphylaxis	☐	☐	☐	☐	☐Epi-Pen
Freq UTI	☐	☐	☐	☐	☐Nitrofurantoin
Jet Lag	☐	☐	☐	☐	☐Ambien
Motion Sickness	☐	☐	☐	☐	☐Scopolamine Patch

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

Additional Comments:

AITC Clinician Signature: Date: