Delaware Valley ID Associates
PATIENT REGISTRATION FORM

Patient Last Name: _____ First: _____ Middle Init: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone #: _____ 2nd Phone #: _____ 3rd Phone #: _____

May we leave a message regarding confidential information pertaining to your health status and/or test results on your…

Preferred Phone? Y or N 2nd Preferred Phone?: Y or N 3rd Preferred Phone?: Y or N

Date of Birth: _____ Email: _____ Sex: Male or Female

Race: White African American Hispanic Asian American Indian Native Hawaiian Other _____

Ethnicity: Hispanic/Latino Not Hispanic/Latino Other _____

Is your preferred language ENGLISH? Y or N If no, please indicate preferred language: _____

IN CASE OF EMERGENCY, WHOM SHOULD WE CONTACT?

Name: _____ Relationship: _____

Home Phone #: _____ Work Phone #: _____ Cell #: _____

May we share your personal health information with the emergency contact? Y or N

Is there a person(s) with whom we may share your personal health information (other than the emergency contact)? Y or N

If yes, Name: _____ Relationship: _____ Phone #: _____

Name : _____ Relationship: _____ Phone #: _____

FAMILY PHYSICIAN: _____ Phone# _____

Address, City, State _____ Fax# _____

REFERRING PHYSICIAN: _____ Phone# _____

Address, City, State _____ Fax# _____

LOCAL PHARMACY: _____ Phone# _____

Address, City, State: _____

MAIL ORDER PHARMACY: _____ Phone #: _____

Address, City, State: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I understand and agree that Delaware Valley I.D. Associates, P.C. and its employees and agents may use and disclose protected health information about me for payment, treatment and/or health care options.

I request that payment of authorized insurance benefits be made either to me or on my behalf to Delaware Valley I.D. associates, P.C. for any services furnished to me by Delaware Valley I.D. Associates, P.C. and its employees and agents. I authorize any holder of medical information about me to release to the insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Patient or Guardian Signature Date

Name_____ **DOB**_____

PLANS:

Estimated departure date:_____ Estimated return date: _____ Duration of travel: _____

Please check all that apply:

____ Sightseeing
____ Camping, rural, labor (agriculture, forestry)
____ Visiting family
____ Urban Business
____ Medicine or public health
____ Other_____

ITINERARY:

COUNTRY and ACCOMMODATIONS List the countries you will visit in order of travel and indicate next to each country the type of living conditions: P = primitive S = standard

1._____ _____
2._____ _____
3._____ _____
4. ._____ _____
5. ._____ _____
6. ._____ _____

INTERNATIONAL TRAVEL MEDICAL QUESTIONNAIRE	**YES**	**NO**
1. Do you have any medical condition that warrants maintenance medications or physician follow-up?	_____	_____
2. Do you have a medical condition that is stable now, but that may recur while traveling?	_____	_____
3. Have you had a fever in the past 48 hours?	_____	_____
4. Are you pregnant or might you become pregnant on this trip?	_____	_____
5. Do you have AIDS, an AIDS-like condition, any other immune disorder, leukemia, or cancer?	_____	_____
6. Do you have severe thrombocytopenia (low platelet count) or a bleeding disorder?	_____	_____
7. Have you ever had a convulsion, seizure, or epilepsy?	_____	_____
8. Do you have any stomach conditions?	_____	_____
9. Do you have bowel conditions such as diarrhea or constipation?	_____	_____
10. Have you ever had hepatitis or yellow jaundice?	_____	_____
11. Do you have a history of psychiatric problems?	_____	_____
12. Do you have a problem with strange dreams and/or nightmares?	_____	_____

Name_____**DOB**_____

13. Do you have insomnia? _____ _____
14. Do you have psoriasis? _____ _____
15. Do you have any eye conditions? _____ _____
16. Are you prone to motion sickness? _____ _____
17. Do you or any member of your household receive any immunosuppressive drugs (steroids, cortisone, anti-cancer treatment)? _____ _____
18. Have you ever had a skin test for tuberculosis? _____ _____
19. Have you ever fainted from having your blood drawn or from an injection? _____ _____
20. Have you ever developed a fever after receiving a vaccination? _____ _____
21. Have you ever had any bad reactions or side effects from any vaccinations? _____ _____

CURRENT MEDICATIONS

	Medication	Dosage and Frequency
1.		
2.		
3.		
4.		
5.		

MEDICATION QUESTIONNAIRE	**YES**	**NO**
Are you taking or do you have a prescription for:		
1. conduction defect or arrhythmia?	_____	_____
2. quinine, quinidine, or medications for a cardiac conduction defect?	_____	_____
3. chloroquine or mefloquine to prevent malaria?	_____	_____
4. steroids, prednisone, or cortisone?	_____	_____
5. antibiotics?	_____	_____

Name_____**DOB**_____

6. Pepto-Bismol to prevent travelers' diarrhea? _____ _____
7. antacids? _____ _____
8. oral contraceptives? _____ _____
9. aspirin therapy? (children and adolescent) _____ _____
10. medications for emotional problems? _____ _____
11. medications for seizures, convulsions, epilepsy? _____ _____

ALLERGIES

Are you allergic to:	**YES**	**NO**
any medications? If yes, please list	_____	_____
_____		
_____		
penicillin?	_____	_____
sulfa?	_____	_____
mercury or thimerosal?	_____	_____
gentamicin?	_____	_____
cipro or levaquin?	_____	_____
neomycin?	_____	_____
polymyxin?	_____	_____
streptomycin?	_____	_____
sulfites?	_____	_____
aluminum or aluminum hydroxide?	_____	_____
2-phenoxyethanol?	_____	_____
bee stings, or have a history of hives or urticaria?	_____	_____
yeast?	_____	_____
eggs?	_____	_____

Name_____DOB_____

Are you hypersensitive to gelatin? _____ _____

Are you hypersensitive for beef protein, soy, casein, phenol, or formaldehyde? _____ _____

Other health problems or illness NOT listed above? _____ _____
If yes, please explain below:

_____

_____

_____

_____

_____

_____

Name_____ **DOB**_____

INFORMED CONSENT (To be signed at the time of your visit)

I have been informed of the possible reactions to these inoculations and any medicines prescribed for travel. I have had the opportunity to ask questions about these inoculations of medications. I understand the benefits and risks involved, and hereby request that the above referenced immunizations be administered to me.

I understand that these immunizations will not necessarily provide protection against the diseases they are intended to prevent.

I understand that when vaccines commonly associated with side effects are given simultaneously, the side effects could be accentuated. I understand that severe sensitivity to materials used in production of vaccines such as chicken or duck eggs precludes administration. Similarly, diseases associated with altered immunity such as certain cancers and treatment, which alter the immune status; such as steroids, cancer chemotherapy or radiation, HIV disease, may also preclude vaccination. Finally, pregnancy usually precludes vaccination with live virus vaccines.

Additionally, the side effects of prescriptions and samples, which I have been given, have been discussed with me.

NAME	SIGNATURE	DATE
WITNESS	SIGNATURE	DATE

LIVE VACCINE CONSENT (Pregnancy) (To be signed at the time of your visit – if applicable)

I am receiving a live vaccine. I am not pregnant and I agree to prevent pregnancy for the next three (3) months.

NAME	SIGNATURE	DATE
WITNESS	SIGNATURE	DATE

Name_____ **DOB**_____ **TEMP**_____

THIS SIDE TO BE FILLED OUT BY TRAVELER
Indicate to the best of your knowledge with a YES or NO answer. Include date.

THIS SIDE TO BE FILLED OUT BY PHYSICIAN'S OFFICE.

ROUTINE IMMUNIZATIONS

	YES	NO	DATE	ORDERED	DATE	DATE	DATE
Diphtheria-Tetanus Td							
Diphtheria-Pertussis-Tetanus Tdap							
Hepatitis B							
Influenza							
MMR							
Polio: Injectable (IPV)							
Primary Series							
Last Booster							
Pneumovax							
Varicella							
PPD							

REGULATED IMMUNIZATIONS

	YES	NO	DATE	ORDERED	DATE	DATE	DATE
Yellow Fever							

RECOMMENDED IMMUNIZATIONS

	YES	NO	DATE	ORDERED	DATE	DATE	DATE
Hepatitis A							
Twinrix (Hep A/B)							
Immune Globulin							
Meningococcal:							
Menomune							
Menactra							
Typhoid Oral							
Typhoid Injectable							
Rabies Pre-Exposure							
Rabies Post Exposure							
Japanese Encephalitis							
Malaria Prophylaxis							

Name_____ **DOB**_____

MALARIA PROPHYLAXIS

BUG REPELLENT WITH 30% DEET - Read and follow all directions and precautions on this product label.
PLAQUENIL OR CHLOROQUINE - Take_____tablet(s) once a week beginning one week prior to departure, weekly while in the endemic country(s), and for four weeks after leaving the endemic country(s).
DOXYCYCLINE – Take one tablet daily beginning two days prior to departure, daily while in the endemic country(s) and daily for four weeks upon leaving the endemic country(s).
MEFLOQUINE (LARIAM) – Take one tablet weekly, starting one week prior to departure. Continue taking one weekly during travel in the endemic country(s) and one weekly for four weeks after leaving the endemic country(s).
ATOVAQUONE/PROGUANIL HCL (MALARONE) – Take one tablet daily beginning two days prior to departure, daily while in the endemic country(s) and daily for seven days upon leaving the endemic country(s).

***SEEK IMMEDIATE MEDICAL ATTENTION IF YOU GET HIGH FEVER, SHAKING CHILLS, AND/OR PROSTRATION**.

INFORMATION REGARDING TRAVELERS' DIARRHEA

You may be able to prevent diarrhea by using two chewable Pepto-Bismol tablets four times a day. Do not use if you are taking Doxycycline.
Use_____, tablet(s)_____times daily for three days if you develop severe diarrhea. See physician if not better in 24-48 hours. You may use Imodium AD only if diarrhea is restricting activities. If diarrhea is severe, bloody, or accompanied by fever, contact a doctor.

INFORMATION REGARDING ALTITUDE SICKNESS

Use Acetazolamide (Diamox), _____ tablet(s) _____ times daily beginning 24 hours before ascent, continuing during ascent, and for 48 hours after arrival at high altitude.

INFORMATION I HAVE RECEIVED INCLUDES

Advice To Travelers handout
Yellow book international certificate of vaccination
Vaccine specific advisory sheets for each vaccine I have opted to receive

***IF YOU WERE GIVEN ORAL TYPHOID VACCINE, IT MUST BE KEPT REFRIGERATED AND TAKEN EXACTLY AS DIRECTED.**
NOTES:_____

_____

_____
Patient's Signature

_____
Patient's Name (please print) Date

_____
Jerome Santoro, M.D.
Mark J. Ingerman, M.D.
Lawrence L. Livornese Jr., M.D.
Brett C. Gilbert, D.O.
Bevin L. Dolan, M.D.
Kiran Paramatmuni, M.D.
Fredy Chaparro, M.D.

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. ePrescribing greatly reduces medication errors, and enhances convenience for the patient while maximizing patient safety. The ePrescribe Program includes:

- **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.

- **Fill status notification** - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.

- **Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

By signing this consent form you are agreeing that Delaware Valley ID Associates may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Delaware Valley ID Associates to enroll me in the ePrescribe Program.

_____ _____

Print Patient Name Date of birth

_____

Signature of Patient (or Guardian)