



Date:

How did you learn about TRAVEL M.D.[®] ?

PATIENT INFORMATION

<input type="checkbox"/> New	<input type="checkbox"/> Existing	Are you a new or existing patient of Travel M.D.?	
Legal Name, Last:	<input type="text"/>	Address Line 1:	<input type="text"/>
Legal Name, First:	<input type="text"/>	Address Line 2 (apt. #):	<input type="text"/>
Legal Name, Middle:	<input type="text"/>	City:	<input type="text"/>
Sex:	<input type="text"/>	State:	<input type="text"/>
Date of Birth:	<input type="text"/>	Zip:	<input type="text"/>
Marital Status:	<input type="text"/>	Language:	<input type="text"/>
Soc. Sec Number:	<input type="text"/>	Race:	<input type="text"/>
Phone:	<input type="text"/>	Weight (if under 18 yrs.):	<input type="text"/>
Cell Phone:	<input type="text"/>	Age:	<input type="text"/>
Can we leave message on your voicemail?:	<input type="text"/>	Email Address:	<input type="text"/>

PATIENT EMPLOYMENT INFORMATION

Employer or School:	<input type="text"/>	Address Line 1:	<input type="text"/>
Work Phone:	<input type="text"/>	Address Line 2 (apt. #):	<input type="text"/>
Extension:	<input type="text"/>	City:	<input type="text"/>
Occupation:	<input type="text"/>	State:	<input type="text"/>
Employment Status	<input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Unemployed	Zip:	<input type="text"/>

GUARANTOR INFORMATION– Information on who's financially responsible for the patient

Same as Patient Information

Relationship to Patient:	<input type="checkbox"/> Spouse <input type="checkbox"/>	Legal Name, Last:	<input type="text"/>
Soc. Sec Number:	<input type="text"/>	Legal Name, First:	<input type="text"/>
Sex:	<input type="text"/>	Legal Name, Middle:	<input type="text"/>
Date of Birth:	<input type="text"/>	Address Line 1:	<input type="text"/>
Marital Status:	<input type="text"/>	Address Line 2 (apt. #):	<input type="text"/>
Phone:	<input type="text"/>	City:	<input type="text"/>
Can we leave message at this number?:	<input type="text"/>	State:	<input type="text"/>
		Zip:	<input type="text"/>



GUARANTOR EMPLOYMENT INFORMATION

Employer or School:		Address Line 1:	
Work Phone:		Address Line 2 (apt. #):	
Extension:		City:	
Occupation:		State:	
Employment Status	<input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Unemployed	Zip:	

INSURANCE INFORMATION

Name of Insurance		Relation to Policy	
Policy Holder's Name, Last:		Policy Holder SSN:	
Policy Holder's Name, First:		Policy Holder DOB:	
Policy Holder's Name, Middle:		Did you verify if your plan covers Travel M.D.:	

Your Primary Care Physician

Name:		Address:	
Phone:		City:	
Did he/she refer you to Travel M.D.:		State:	
		Zip:	

Your Pharmacy

Name:		Address:	
Phone:		City:	
		State:	
		Zip:	

PAYMENT GUARANTEE

Payment for services rendered at TRAVEL M.D.[®] is required at the time of service. We accept payment by check or credit card. Insurance coverage for TRAVEL M.D.[®] varies greatly. **Your visit is billed as an Outpatient Service with a primary diagnosis of V65-49, "Other Specified Counseling."** Please call your insurance carrier PRIOR to your appointment to verify coverage. If this is a covered service we will file your claim with your insurance carrier. Atlantic Health will bill you for any charges not covered after being sent to your carrier. Please keep in mind that the billing of insurance is a courtesy to you. Your insurance policy is a contract between you and your insurance company. Communication with your insurance company is your responsibility.

IF YOU ARE A MEDICARE PATIENT, TRAVEL M.D. SERVICES ARE NOT COVERED AND PAYMENT IS ALWAYS REQUIRED AT THE TIME OF SERVICE.

I ACCEPT THE PAYMENT TERMS AS DETAILED ABOVE:

Patient/Guarantor Signature

MEDICAL HISTORY

Do you have any medication allergies? If so, please list the medication and your allergic symptoms. If not, please enter "none."

Are you allergic or hypersensitive to any of the following? Select all that apply.

- 2-phenoxyethanol
- Aluminum or aluminum hydroxide
- Amino glycoside antibiotics (Streptomycin, Neomycin, Kanamycin, Gentamicin)
- Amphotericin B
- Bee stings or have a history of hives
- Beef protein, soy casein, lactose, phenol, or formaldehyde
- Eggs
- Gelatin
- Latex
- Mercury or Thimerosal
- Polymixin
- Sulfites
- Sulfa
- Yeast
- None

Please select the health conditions that currently apply to you.

- Allergies
- Anti-coagulation (Coumadin) treatment
- Asthma or other breathing problems
- Cancer (type)
- Diabetes
- Fever – in last 48 Hours
- Heart Disease
- HIV/AIDS
- Immune Compromised
- Pregnant **or** suspect you may be pregnant
- Psychiatric Disorder
- Seizures
- Stomach disorder (GERD/peptic ulcer disease)
- Other (please describe)
- None

Date of last menstrual

Are you breast feeding:

TRAVEL M.D.[®] of Atlantic Health

(to move through form, use the tab key or left mouse button)



Please list the name/dose/frequency of your current prescription medications, over-the-counter medicines, and vitamin and herbal supplements. If you are not taking any, please enter "none."

Please select the vaccines that you have had in the past and the approximate date that the vaccination was completed. If you are unsure of the vaccination date, please enter "don't know."

<input type="checkbox"/> Diphtheria/Tetanus (dT)	Date:	
<input type="checkbox"/> Hepatitis A	Date:	
<input type="checkbox"/> Hepatitis B	Date:	
<input type="checkbox"/> Immune Globulin (or other blood product)	Date:	
<input type="checkbox"/> Influenza	Date:	
<input type="checkbox"/> Japanese Encephalitis	Date:	
<input type="checkbox"/> Measles, Mumps & Rubella (MMR)	Date:	
<input type="checkbox"/> Meningococcal	Date:	
<input type="checkbox"/> Pneumococcal	Date:	
<input type="checkbox"/> Polio (injection)	Date:	
<input type="checkbox"/> Polio (oral)	Date:	
<input type="checkbox"/> Rabies	Date:	
<input type="checkbox"/> Typhoid	Date:	
<input type="checkbox"/> Varicella (chicken pox)	Date:	
<input type="checkbox"/> Yellow Fever	Date:	
<input type="checkbox"/> Other (please describe and list date):		

Have you had an adverse reaction to a vaccine? If so, please list vaccine and your symptoms. If not, please enter "none."

Please make any additional comments that you may have.



TRAVEL ITINERARY

Date of Departure:

Date of Return:

Please list each county and city that you are planning to visit and include the length of stay in each destination. Please list them in the order that you will visit them.

Country	City	Length of Stay (days)

What type of places will you visit? Select all that apply:

- City and urban areas
- Rural Areas – staying in hotels
- Rural Areas – camping
- Beaches
- Tropical jungle
- High altitude (over 4000 feet)
- Snow/mountainous terrain
- Other (please describe):

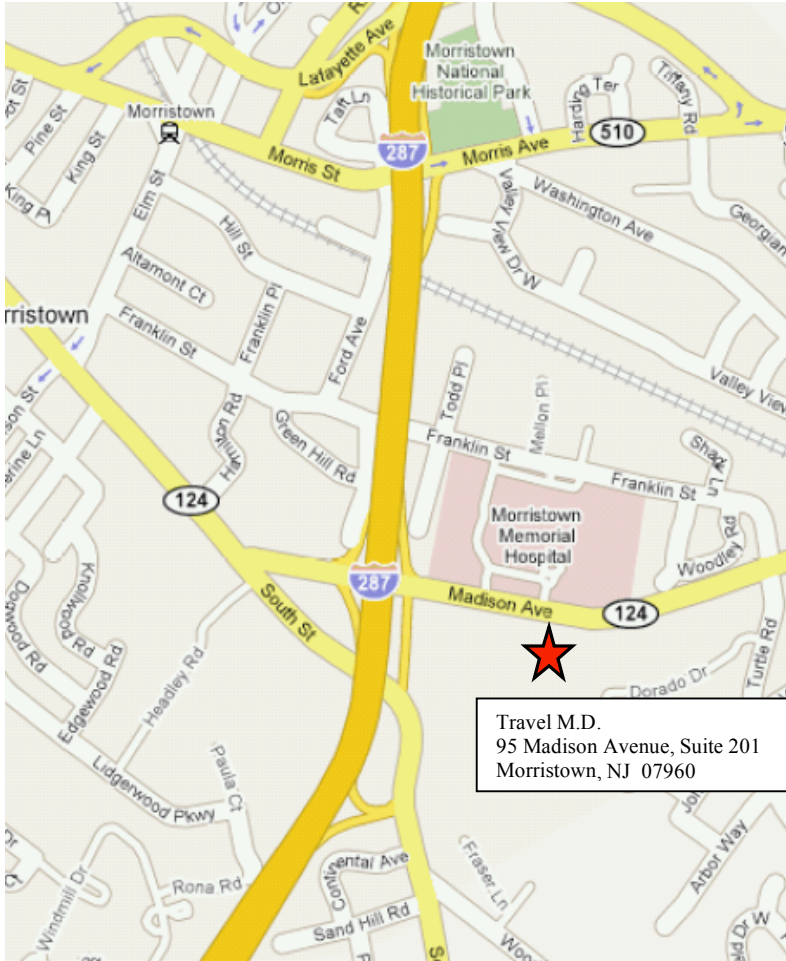
What is the purpose of your travel? Select all that apply:

- Business
- Pleasure/Vacation
- Study abroad
- Humanitarian

Please select the geographic areas that you have traveled to in the past three years. Select all that apply:

- I have not traveled outside of the United States
- Africa
- Asia
- Central/South America
- Europe/Australia
- India
- Other (please describe):

LOCATION & DIRECTIONS

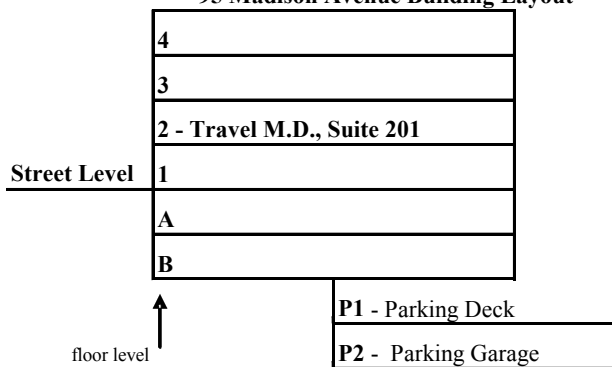


Travel M.D.
 95 Madison Avenue, Suite 201
 Morristown, NJ 07960
 (973) 971-7291

FROM THE NORTH
 South on Rt 287, exit 35 (Madison Ave).
 Left at traffic light onto Madison Ave.
 Right into 95 Madison Ave. immediately following 1st traffic light.

FROM THE SOUTH
 North on Rt. 287, exit 35 (South St.)
 Left at traffic light onto South St.
 1st right onto Madison Ave. access road
 Right turn at stop sign onto Madison Ave.
 Right into 95 Madison Ave. immediately following 1st traffic light.

95 Madison Avenue Building Layout



Handicap parking is available street level in front of 95 Madison. Enter the building and walk to the elevators and go up to Floor 2. Exit elevator, turn left, you are now facing Travel M.D. in Suite 201.

Patient parking is available in rear of 95 Madison. Access the elevators on either Level P2 or P1 and go UP to Floor 2. Exit elevator, turn left, you are now facing Travel M.D. in Suite 201.



Travel M.D.®
95 Madison Avenue, Suite 201
Morristown, NJ 07960
973-971-7291

Patient:

Services			
CPT Code	# Completed	Description	Price
99403		Travel counseling	\$85
99411		Travel counseling - additional person	\$75
99402		Nurse Visit	\$50
99429		International Certificate of Vaccination (replacement)	\$23
81023		Urine Pregnancy Test	\$65
Immunizations			
CPT Code	# Completed	Description	Price
90471		Vaccine Administration	\$20
90472		Vaccine Administration (each additional)	\$13
90632		Hepatitis A adult, each (2 dose series)	\$95
90633		Hepatitis A pediatric, each (2 dose series)	\$90
90746		Hepatitis B adult, each (3 dose series)	\$80
90744		Hepatitis B pediatric, each (3 dose series)	\$75
90281		Immune Globulin	\$55
90659		Influenza	\$25
90735		Japanese Encephalitis, each (2 dose series)	\$315
90735		Japanese Encephalitis pediatric, each (3 dose series)	\$185
86580		Tuberculin PPD	\$17
90705		Measles	\$32
90707		Measles/Mumps/Rubella	\$75
90734		Meningococcal Conjugate (Menactra)	\$150
90733		Meningococcal Polysaccharide (Menomune)	\$150
90704		Mumps	\$50
90732		Pneumococcal Polysaccharide	\$53
90713		Polio injectable	\$58
90675		Rabies, each (3 dose series)	\$250
90706		Rubella	\$48
90715		Tetanus Diphtheria Pertusis (Tdap)	\$95
90718		Tetanus Diphtheria (Td)	\$30
90690		Typhoid oral	\$80
90691		Typhoid injectable	\$80
90636		Hepatitis B recomb/ Hep A (Twinrix), each (3 dose series)	\$165
90716		Varicella	\$160
90717		Yellow fever	\$140

NPI# 1053384776

Tax ID# 52-1958352

Date of Service / /

Amount Due \$0

Submit to insurance
 Corporate Contract
 Self-Pay

Payment type { Check
 Cash
 Credit Card
