The Adventure & Travel Medicine Center
33 West Rahn Rd. Suite 101
Dayton, Ohio 45429
Phone: 937-433-8990
Fax: 937 433-8691 or 937 438-7677

Travel Patient Registration Form

Please fill out this form & fax it back to Luann.

Account # ____________________ **OFFICE USE ONLY**

Patient Name: ________________ SS#: ________ DOB: ________ Sex: M ☐ F ☐

Spouse's Name if Traveling: ________________ SS#: ________ DOB: ________ Sex: M ☐ F ☐

Address: ____

Names of Children (with any applicable insurance id suffix) if Traveling with Patient:

1. ____________ suffix ______ SS# ____________ DOB: ________ Sex: M ☐ F ☐
2. ____________ suffix ______ SS# ____________ DOB: ________ Sex: M ☐ F ☐
3. ____________ suffix ______ SS# ____________ DOB: ________ Sex: M ☐ F ☐
4. ____________ suffix ______ SS# ____________ DOB: ________ Sex: M ☐ F ☐
5. ____________ suffix ______ SS# ____________ DOB: ________ Sex: M ☐ F ☐

Home Phone # ________________ Work Phone # ________________

Cell Ph # ________________ Referring Dr./Clinic: ________________

☐ If this is a **WORK EXPENSE**, please check the box and move on to "Destination".

>>>**DO NOT** fill out the Insurance Information

Insurance Information:

Insurance Address: ____

____

Insurance Phone # ________________ **Note: If applicable, give ALL insured id suffixes**

Insured's ID # ________________ DOB: ________ Sex: M ☐ F ☐

Group # ________________ Copy if applicable ________________

Insured's Name: ________________ Insured's Employer: ________________

Destination: ____

Departure Date: ________________ Return Date: ________________

How Long There: Days _____ Weeks _____ Months _____ Years _____

Is trip for Business? ☐ Missionary? ☐ Pleasure/ Vacation? ☐ Student? ☐

Previous Vaccines? Yes ☐ No ☐

Previous Travel Clinic Patient? Yes ☐ No ☐

For ATC Employees Only:

Insurance Covers: Yes No Payment * Time of Service: Yes No SEE COMMENTS: Yes No

ABN: Yes No Referral Needed: Yes No

Comments: ____

____

Schedule Appointment on: ________________________ ☐ Done

BENEFIT ASSIGNMENT (Check One)/ AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ I hereby authorize my insurance benefits to be paid directly to the above group of physicians, realizing I am responsible to pay non-covered services.

_____ Since I am making payment in full at time of service, I do not authorize insurance benefits to be paid directly to the above group of physicians.

_____ I acknowledge I was offered and/or given a copy of SDACC's Privacy Notice in compliance with HIPAA regulations. I hereby authorize the release of pertinent medical information to insurance carriers. I further authorize that this information may be faxed, so long as reasonable efforts are made to keep confidentiality of such information in the course of transmission.

SOME SERVICES MAY NOT BE COVERED BY YOUR INSURANCE PLAN. ONCE WE RECEIVE THE RESPONSE FROM YOUR INSURANCE, WE WILL BALANCE BILL YOU FOR ANY NON-COVERED SERVICE. PAYMENT IN FULL IS DUE UPON RECEIPT.

Signature ________________________ Date ____________