VIDA Travel Medicine Clinic
Patient Registration Form

Name:____________________________________ Date of Birth: ___________ Gender: _____
Height: _______ Weight: _______
Address:_________________________________ City: ___________ State:___ Zip:_______
Cell/Home: _____________________________ e-mail:_______________________________
Preferred Pharmacy:_________________Pharm Street & City:__________________________

How did you hear about us: MD referral/ internet search/ family/ friend/ prior consultation here

Emergency contact: Name: ___________________________ Cell/Home: __________________

Non-traveling patients: reason for vaccination:____

Traveling patients: Travel dates:___________________ Destination(s):____________________
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Other traveling companions being consulted on:
Name:________________________________ Gender:_______ Date of birth:_______________
Name:________________________________ Gender:_______ Date of birth:_______________
Name:________________________________ Gender:_______ Date of birth:_______________
Name:________________________________ Gender:_______ Date of birth:_______________

Valley Infectious Disease Associates
Travel and Immunization services

I understand all professional services rendered are charged to the patient and fees are collected at the time of service. I understand I am responsible for all fees, regardless of insurance coverage.

I understand Valley Infectious Disease Associates is a separate business, with a separate business license and Tax-ID number from the physicians' medical practices. I understand Valley Infectious Disease Associates Travel Medicine Clinic has no contract with insurance carriers.
I have read and understand the above information.
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Name:_______________________________________ Date:____________________________