GREAT LAKES
PHYSICIAN SERVICES

462 Grider St., Suite 116
Buffalo, NY 14215
716-898-4153

Patient Demographics

Name _____ Address _____
City, State, Zip _____
Home Phone _____
Sex: M___ F___ DOB _____
Last 4 SSN _____
Pharmacy Name _____ Pharmacy Phone # _____
Pharmacy Complete Address _____

Information About Trip:

Destination _____ Date of Departure _____ Length of Stay _____
Please list stops in order of which you will arrive after departing from the U.S.:
_____
_____

Previous Travel Vaccinations (list year they were received)

Hep A #1 _____ Hep A #2 _____
Typoid ____ Injection ____ Oral ____
Yellow Fever ____
Meningitis ____
Japanese Encephalitis #1 ____ Japanese Encephalitis #2 ____
Rabies Series - #1 ____ #2 ____ #3 ____

Please list any adverse reactions to previous vaccinations:

_____
_____

Allergies: _____

Please check yes or no and explain all "yes" answers:

Arthritis / Joint Pain	No ( )	Yes ( )	_____
Asthma / Hayfever / Allergic Rhinitis	No ( )	Yes ( )	_____
Bleeding Tendency / Blood Thinners	No ( )	Yes ( )	_____
Depression / Anxiety / Panic Attacks	No ( )	Yes ( )	_____
Diabetes	No ( )	Yes ( )	_____
Eczema or Psoriasis	No ( )	Yes ( )	_____
Heart Disease / Surgery / Pacemaker	No ( )	Yes ( )	_____
High Blood Pressure	No ( )	Yes ( )	_____
Immune Disorder	No ( )	Yes ( )	_____
(Chemotherapy, HIV, bone Marrow or Organ Transplant, Rheumatoid Arthritis Treatment)			
Impaired Vision or Hearing	No ( )	Yes ( )	_____
Jaundice or Hepatitis	No ( )	Yes ( )	_____

Muscle or Bone Disease	No ( )	Yes ( ) _____
Nervous System Disorder	No ( )	Yes ( ) _____
Renal (Kidney) Disease	No ( )	Yes ( ) _____
Respiratory (Lung) Disease	No ( )	Yes ( ) _____
Seizures / Convulsions / Fainting	No ( )	Yes ( ) _____
Sickle Cell Anemia	No ( )	Yes ( ) _____
Stomach Ulcers / Heartburn / Reflux	No ( )	Yes ( ) _____
Surgery or Hospitalization in past 3 years	No ( )	Yes ( ) _____
Thymus Gland Disorder (Myasthenia Gravis or DiGeorge Syndrome)	No ( )	Yes ( ) _____
Thyroid Disease or Goiter	No ( )	Yes ( ) _____
Tuberculosis	No ( )	Yes ( ) _____
Have you been treated for illness or injury in the past 2 years?	No ( )	Yes ( ) _____

List any prescribed and/or over the counter medications that you currently take (name, dosage, and frequency):

_____

_____

Thank you for choosing Great Lakes Physician Services for your travel immunization needs. At your visit, our experienced providers will consult with you regarding the vaccinations that you are requesting. If you are traveling abroad, our providers will discuss with you all the information you need to help you stay healthy during you trip.

Please be aware that we **DO NOT** participate with any insurance companies. Once you meet with our provider and determine which immunizations you will be receiving, you will be expected to pay for those immunizations along with an office visit fee. If you need to return to complete a series of shots (i.e. Hepatitis B), you will only be charged one office visit fee for the entire series. For family members or small groups that come in together ,there will only be one office visit fee assessed (1-3 people fee is $50, 4-6 people fee is $60, 6 and over will start at $75 but will be determined by size of group. We accept Visa, Master Card, or Cash as means of payment. At the time of payment, you will be provided with itemized receipts that contain all of the information that you will need for insurance submission purposes. We cannot guarantee that your insurance provider will reimburse any of your costs for these services. The amount reimbursed to you, if any, is dependent upon you're the terms of your insurance plan.

By signing below, you are indicating that you have read and understand the above payment terms:

_____ _____ _____

Print Name **Signature** **Date**