TRAVELER INFORMATION

Full Name: _____ Date of Birth: _____ Gender: F / M

Address: _____
Street Address *Apt/Unit #* *Zip Code*

Preferred Phone Number: _____ ☐ Cell ☐ Home OK to leave medical information on voice mail?
☐ Yes ☐ No

Secondary Phone Number: _____ ☐ Cell ☐ Home

Email Address: _____

Referring Physician: _____ Office Phone: _____

Primary Care Physician: _____ Office Phone: _____

Employer: _____ Employer Phone: _____

Pharmacy: _____ Pharmacy Phone: _____

Pharmacy Address: _____

Emergency Contact: _____ _____ _____
Name *Relationship* *Phone Number*

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PAYMENT IS DUE AT THE TIME OF SERVICE. PLEASE BE ADVISED THAT WORLD TRAVEL CARE, LLC, DOES NOT ACCEPT HEALTH INSURANCE AND WE DO NOT ASSIST WITH INSURANCE CLAIM FILING. WE WILL PROVIDE YOU WITH THE NECESSARY INFORMATION TO FILE A CLAIM WITH YOUR INSURANCE IF YOU SO CHOOSE.

PLEASE PRESENT METHOD OF PAYMENT TO THE RECEPTIONIST.

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By signing below, I attest that the above information is correct to the best of my knowledge.

_____ _____
Signature of Patient or Legal Surrogate **Date** **Time**

_____ _____
Printed Name of Patient or Legal Surrogate **Relationship (If Legal Surrogate)**