GLADSTONE
PRIMARY CARE

Lindsay Smith, MD
Juliana Clark, CRNP
301 Pine Street, Suite A
Hartselle, AL 35640
Phone: 256-773-6017
Fax: 256-773-7834

Travel Packet

Dear Patient,

Thank you for choosing Gladstone Primary Care, we look forward to providing you with exceptional care. Enclosed you will find our Travel Forms. Please fill these forms out completely prior to your appointment and return them by fax, mail, e-mail, or in person.

At your first visit, please bring:

- Completed Forms (if you have not already submitted them)
- Your photo ID
- Your insurance card(s)
- Vaccination record
- Yellow card, if applicable
- You will be responsible for your consult and vaccination fees at the time of your visit

We ask you to review all information in this packet carefully and complete the paperwork with as much detail as possible regarding your trip and vaccinations. Please see attached price list for cost of consultation and vaccination.

If you are unable to keep your appointment or need to reschedule for any reason, we ask for a minimum of 48-hour notice.

Sincerely,

Gladstone Primary Care

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PATIENT INFORMATION

Legal Name as it appears on your Government-Issued ID

Last Name: ______________________________ **Date of Birth:** ______________

Last First Middle Initial

Maiden/Other Last Name: ____________________ **Social Security #:** ____________________

Address: ____

City: ____________________ **State:** __________ **Zip:** __________

Email: ____

Cell Number: ____________________ **Home Number:** ____________________

May we contact you on your cell? ☐ Yes ☐ No **May we leave a message on your voicemail?** ☐Yes ☐No

Sex: ☐ M ☐ F ☐ Prefer Not to Say **Marital Status:** ☐ Divorced ☐ Life Partner ☐ Married ☐ Single ☐ Widow

Race: ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other: ______________

Employment Status: ☐Full-Time ☐Part-Time ☐Retired ☐Not Employed ☐Active Military ☐Disabled ☐Housewife ☐Self-Employed

Employer: ______________________________ **Employer Phone:** ____________________

Employer Address: ____

City: ____________________ **State:** __________ **Zip:** __________

Emergency Contact Name: ____________________ **Phone Number:** ____________________

Relationship to Patient: ____________________

Primary Insurance to File

Insurance Company:	Insured's Name:
Policy Number:	Insured's Date of Birth:
Group Number:	Relationship to Patient:
Insured's Social Security Number:	

Secondary Insurance to File

Insurance Company:	Insured's Name:
Policy Number:	Insured's Date of Birth:
Group Number:	Relationship to Patient:
Insured's Social Security Number:	

Person Responsible For Account: ______________________________ **Phone:** ______________

I agree that payment will be made at the time of service. I agree to pay all co-pays, non-covered or routine charges, deductibles and co-insurance amounts that apply. In the event this account is turned over to a collection agency for collection, I will be responsible for all collection fees, court costs and attorney's fees. I authorize Gladstone Primary Care to release information to insurance carriers and for insurance carriers to release information to Gladstone Primary Care concerning my illness, treatment and payments (including workmen's compensation) and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents if assignment applies.

Patient Signature: ______________________________ **Date:** ______________

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Trip Information: Please answer the following in as much detail as possible.

Dates of Travel. Date of departure from U.S.________________________ Date of return to U.S.________________________

What countries will you be visiting? Please list them in order.

Country	City or Region	Length of Stay

Past Medical History: Check all that apply in your **Medical HISTORY**

	Anxiety		COPD		HIV/AIDS		Neurological disorder
	Asthma		CVA/Stroke		Hepatitis A/B/C		Psychiatric disorder
	Bowel Disease		Depression		Hypertension		Seizures
	Chest Pain		Diabetes		Immunodeficiency		Splenectomy
	Chronic Cough		DiGeorge Syndrome		Kidney Disease		Stomach ulcers
	Cancer		DVT or PE		Liver Disease		Thymoma
	Chronic Kidney Disease		Guillain-Barre Syndrome		Lymphoma		Thymectomy
	Cirrhosis		GERD/Acid reflux		Myasthenia Gravis		Trouble swallowing
	Congestive Heart Failure		Heart Attack/Heart Disease		History of organ transplant		G6PD Deficiency

Other Medical Problems: ____

Females: Last Menstrual Period: __________________Method of contraception: __________________________

Are you currently trying to get pregnant? ____Yes ____No

Are you breastfeeding? ____Yes ____No If yes, is the child under 9 months of age?____Yes ____ No

Vaccination History:

	Never	Unsure	Yes, please list date
Chickenpox			
Hepatitis A			
Hepatitis B			
Influenza			
Japanese Encephalitis			
Meningococcal			
MMR			
Pneumococcal			
Polio			
Tetanus/Diphtheria			
Typhoid Injectable			
Typhoid Oral			
Yellow Fever			
Other (Specify)			

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Medications and Allergies

Your PREFERRED Pharmacy (Name & Location): ____________________

Medications: List all current medications including over the counter (Please also bring bottles to each appointment)

Medication	Dosage/Strength (MLs or MGs)	Frequency per Day

List all Allergies including environmental and medication:

Allergic to:	Type of Reaction:

Social History:

Smoke Cigarettes: No _____ Yes _____ Former Smoker: _____ If yes, how many per day? __________

If former, how long ago did you quit? _______________ Vape: No _____ Yes _____

Smokeless Tobacco: No _____ Yes _____

Drink Alcohol: No _____ Yes _____ If yes, how much per day? ______________________

Illegal Drugs: No _____ Yes _____ If yes, what, and how much? ______________________

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Consent Form

Patient Name: ______________________________________ Date of Birth: ____________________

I authorize the release of my health information necessary to my treatment, continuity of care, and the processing of insurance claims to the following entities:

Individual Insurance Companies | Billing Services | Providers Associated with Care
Hospital Lab and Ancillary Departments | Agencies Associated with Care/EMR

By signing below, you are signifying that you understand and agree to the release of your health information to the above listed entities for the purposes outlined.

Patient/Guardian Signature: ____________________________________ Date: __________________

Relationship to Patient: ____

List any person(s) who we may speak to regarding your health information or that we may obtain your health information from, including family members, relatives, significant others:

Name	Relationship	Phone Number

Insurance release/assignment of benefit/payment authorization:
Your fee for service is due and payable by cash, check, credit card, or debit card at the time of treatment. We may not participate in all insurance plans and if your plan is one in which we do not participate, please ask for an office receipt so you can file for reimbursement if applicable. Regardless of any insurance, the guarantor listed on the Patient Information Form is responsible for his/her bill. The guarantor will also be responsible for all charges incurred by collection agencies or past due accounts.

By signing below, you are signifying that you understand and agree to the office and financial policies and the information regarding financial responsibility contained in the Patient Packet. You are agreeing to the release of your health information to the person(s) listed on this form. This listed of designated people can be updated at any time.

Patient/Guardian Signature: ____________________________________ Date: __________________

Relationship to Patient: ____