

Email to: hs-ivisitors@ucdavis.edu

Mail to: International Patient Services 4610 X Street, Suite 2301 Sacramento, CA 95817 USA

## Fax to: +1.916.734.1366

## INTERNATIONAL PATIENT INFORMATION FORM

Contact Information						
Patient Name	First					
	Middle					
	Last					
Contact Information	Phone					
Fax						
	Cell					
Email (required)						
Home Address						
Name of U.S. Point- of-Contact (if any)	Name					
	Phone					
Cell						
Email						
Address						
Emergency Contact	Name					
(spouse, sibling, adult child, etc. If patient is a child, parent must be listed)	Phone					
	Cell					
	Email					
Address						
Referring Physician in Home Country (if any)	Name					
	Phone					
	Fax					
Email						
Address						

## **International Patient Information Form**

## UC Davis Health

Medical Information								
Date	of Birth							
F	Religion							
Gender		🗆 Male 🛛 🗆 Fem		□ Female				
Marital Status			□ Married	🗆 Divore	ced 🗆 Widowed			
Diagnosis <sup>1</sup>								
Preferred Specialist								
erence		Iale Physician	□ Female Ph	5	□ No Preference			
Financial Information								
Preferred Method of Payment			□ Cash/Check □ Credit Card		□ Insurance			
Depending on your preferred method of payment, please be prepared to provide: proof of ability to pay cash, credit card information, or proof of insurance and evidence that it is valid for care provided in the U.S.								
Additional Services Requested								
Please indicate if the patient or their family requires assistance with any of the following:								
Interpreter Services (indicate language)								
Accommodations								
Transportation from Airport								
ent mig	ht have							
	Marita Dia Dia erred Sp erence od of P ferred n l inform l inform te if the preter S icate lan commo n from cate any ent mig	Marital Status Diagnosis <sup>1</sup> erred Specialist erence DN od of Payment ferred method o l information, or the if the patient preter Services icate language) commodations	Religion Gender   Marital Status Single   Diagnosis <sup>1</sup> Single   Diagnosis <sup>1</sup> Single   erred Specialist Single   erred Specialist Male Physician   od of Payment Cash/Cl   ferred method of payment, ples Information, or proof of insurprovided in the   atte if the patient or their family preter Services   icate language) commodations   n from Airport Sate any special   ent might have Sate Any	Religion Image: Single im	Date of Birth Religion   Religion Image   Marital Status Image   Diagnosis <sup>1</sup> Image   Perred Specialist Image   erred Specialist Image   of of Payment Image   Image Image   I			

<sup>&</sup>lt;sup>1</sup> Please include any relevant medical records/files translated into English