

Email to: ivisitors@ucdmc.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					
Е	mail (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.	Phone					
If patient is a child, parent must be listed)	Cell					
	Email					
Address						
Referring Physician in Home Country (if any)	Name					
	Phone					
	Fax					
Email						
Address						

### **International Patient Information Form**

### UC Davis Health

Medical Informati								
Date	of Birth							
F	Religion							
Gender		🗆 Male 🛛 Fen		□ 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							
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<sup>&</sup>lt;sup>1</sup> Please include any relevant medical records/files translated into English