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Mail to: International Patient Services

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Sacramento, CA 95817 USA

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 (spouse, sibling, adult child, etc. If patient is a child, parent must be listed)	Name	
	Phone	
	Cell	
	Email	
	Address	
Referring Physician in Home Country (if any)	Name	
	Phone	
	Fax	
	Email	
	Address	

Medical Information				
Patient Information	Date of Birth			
	Religion			
Gender		☐ Male	☐ Female	
Marital Status		☐ Single	☐ Married	☐ Divorced ☐ Widowed
Diagnosis ¹				
Preferred Specialist				
Preference		☐ Male Physician	☐ Female Physician	☐ 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				
Please indicate any special needs/requests the patient might have (attach additional pages as needed):				

¹ Please include any relevant medical records/files translated into English