UCDAVIS HEALTH

Email to: ivisitors@ucdmc.ucdavis.edu

Fax to: +1.916.734.1366

Mail to: International Patient Services
4610 X Street, Suite 2301
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