Stanford HEALTH CARE
STANFORD MEDICINE

INTERNATIONAL MEDICAL SERVICES
300 Pasteur Drive, H 1111
Palo Alto, CA 94305
Tel: (650) 723-8561
FAX: (650) 723-5704

INTERNATIONAL PATIENT INFORMATION FORM
Contact Information

Patient Name:

_____
(Last) *(First)* *(Middle)*

Date of Birth: _____ **Sex:** **M** **F** U.S. Social Security # _____
(if patient has one)

Foreign Address:

_____

_____

_____

Tel: _____ Fax: _____

Cellular: _____ E-Mail: _____

US Address for Billing: (If you do not have US address, please leave this section blank.)
**Please note all patients can access their billing information on MyHealth.*

_____

_____

_____

Patient Employment Information:

Name of Employer: _____ Occupation: _____

Address: _____

_____

_____

Tel: _____ Fax: _____

U.S. Contact *(if any)*

Contact Name: _____ Relationship: _____

Address: _____

_____

Tel: _____ Fax: _____

Cellular: _____ E-Mail: _____

Medical Information

Patient Diagnosis*: _____

*Please attach copies of all medical records/files (translated in English). Documents must be in PDF format. Please do not send files via Dropbox, Google Drive or other external sites.

Special Appointment Requests/Patient Availability

_____

_____

International Insurance

International Insurance can be used for all estimated services above $1,000. It will only be billed if there is a US billing address. We require a written letter of guarantee from the insurance company including policy maximum, deductibles, and exclusions. Please attach photocopies of front and back of insurance cards.

IMS Services Requested

Please indicate if the patient/patients family requires assistance with any of the following:

Interpreter Services	Yes	No	If yes, indicate the language _____
Accommodations	Yes	No	If yes, indicate price range _____
Airport Transportation	Yes	No	If yes, indicate the flight information and number of persons traveling _____

Please indicate any special needs/requests the patient might have *(attach additional page as needed)*:

_____

_____

_____

Referral Information

Who referred you to us? *(Please provide name, relationship, and contact information)* _____

_____

How did you hear about us? *(Check all that apply)*

□ Physician Referral	□ Stanford Medical Forums	□ Reputation	□ Other: *(please specify)*
□ Friend, Relative	□ Website	□ Media	_____