Reset Form

Print Form

UW Medicine International Patient Program

Demographics and Intake Form

FOR INTERNAL USE ONLY
Patient MRN:

PATIENT INFORMATION			
Legal Surname	Legal First Name	Legal Middle Name	
Preferred Name	Suffix	Date of Birth (MM/DD/YYYY)	Gender
All Languages Spoken by Patient	Preferred Spoken Language	Preferred Written Language	

Permanent Address in Home Country		
Street	APT	City
State/Province	Zip/Postal Code	
Phone Number	Mobile Phone Number	Email Address
Address of Residence in US (if applicable)		
Do You Have a Passport? ☐ Yes ☐ No	Country of Issue	Do You Have a Visa? ☐ Yes ☐ No
Payment Method ☐ Self-Pay ☐ Insurance ☐ Embassy (Please include Insurance or Embassy contact details below)		

EMERGENCY CONTACT or REPRESENTATIVE INFORMATION	
Name	Relationship to Patient
Phone Number	Mobile Phone Number
Address	
Email	Languages Spoken

PHYSICIAN INFORMATION		
Physician's Name in Home Country		Physician's Medical Specialty
Physician's Phone Number	Physician's Fax Number	
Physician Languages Spoken		Date of Last Examination

ADDITIONAL PHYSICIAN INFORMATION		
Physician's Name in Home Country		Physician's Medical Specialty
Physician's Phone Number	Physician's Fax Number	
Physician Languages Spoken		Date of Last Examination

PATIENT'S DIAGNOSIS/SYMPTOM INFORMATION
Patient's Diagnosis/Symptoms
What care are you looking for at UW Medicine? For example, what care are you hoping for that cannot be provided in the patient's home country?
Which Specialty Clinic and/or Specific Clinic would you like to be seen in?