



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: _____

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).

Special Appointment Requests/Patient Availability

Payment Information

Method of Payment: *(Please Circle)*

Cash *MC / Visa / American Express Check **International Insurance

*Cardholder's name: _____ Card #: _____ Exp. Date: _____

**International Insurance can be used for all estimated services above \$1,000. 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 _____

Transportation from Airport 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 _____