UCSF Medical Center
UCSF Benioff Children's Hospital

UCSF Medical Center
International Services

**1500 Owens Street, Suite 360**
**San Francisco, CA 94158**
**415-353-8489 Fax: 415-353-3672**
**international@ucsfmedctr.org**

**Patient Information and Registration Form** (*indicates required information)

Full name*: _____
(Family Name) (First Name) (Middle Name)

Address*: _____

City/Country/Postal Code*: _____

Phone/Cell/Mobile #*: _____

Email*: _____

Date of Birth*: _____ Age: _____ Place of Birth: _____
(Month/Day/Year) (Country)

Sex*: ☐ Male ☐ Female Nationality*: _____ Religion: _____

Ethnicity*: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Declined

Race*: ☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian/Pacific Islander ☐ Other ☐ White or Caucasian ☐ Unknown/Declined

U.S. Social Security Number (if applicable): _____

Passport Identification Number: _____

Marital Status*: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated
☐ Registered Domestic Partner (RDP) ☐ RDP-Dissolved ☐ RDP- Widowed

Preferred Language*: _____

Interpreter Needed*? ☐ Yes ☐ No

Occupation (parent, if minor): _____
Length of Employment: _____
Employer's Name: _____
Address: _____
City/State, Country: _____
Telephone: _____
Email: _____

UCSF Medical Center
UCSF Benioff Children's Hospital

UCSF Medical Center
International Services

**1500 Owens Street, Suite 360**
**San Francisco, CA 94158**
**415-353-8489 Fax: 415-353-3672**
**international@ucsfmedctr.org**

Emergency Contact* (Spouse/Next of Kin/Relative)
Name: _____
Address: _____
City/State, Country _____
Relation: _____
Telephone: _____

Local Contact Information: (How can we contact you after you arrive?)
Name: _____
Address: _____
City/State, Country _____
Relation: _____
Telephone: _____

Treatment being sought: (Please provide information)
Patient's Diagnosis: _____
Preferred Specialist/MD: _____

Payment Method: ☐ Cash ☐ Cashiers/Traveler's Check/Check (drawn on U.S. bank account)
☐ Wire Transfer ☐ International Insurance (requires a U.S.-based third-party administrator)

Credit Card (Preferred Method)

☐ Visa ☐ MasterCard ☐ American Express ☐ Other: _____

If your insurance approved treatment and will pay for all costs, please provide:

Insurance Company Name: _____

Send bills to (claims address): _____

City, State/Country/Zip: _____

Telephone #/Contact Person: _____

Group #: _____ Subscriber/Policy #: _____
Authorization #: _____ Reference#: _____

How did you hear about UCSF?

☐ Friend/Family ☐ Physician Referral ☐ Internet search/UCSF Website ☐ Reputation ☐ Other: _____

UCSF Medical Center

UCSF Benioff Children's Hospital

UCSF Medical Center
International Services

**1500 Owens Street, Suite 360**
**San Francisco, CA 94158**
**415-353-8489 Fax: 415-353-3672**
**international@ucsfmedctr.org**