



INTERNATIONAL MEDICAL SERVICES
300 Pasteur, H1111
Palo Alto, CA 94305
Tel: (650) 723-8561
Fax: (650) 723-5704

INTERNATIONAL PEDIATRIC 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** _____

Name of Mom (include Maiden Name) _____ **Mom's Date of Birth** _____

Name of Dad _____ **Dad's Date of Birth** _____

U.S. Contact (if any)

Contact Name : _____ Relationship _____

Address: _____

Local Tel: _____ Local Fax: _____

Medical Information

Has the patient had chicken pox? Yes No Measles? Yes No

Patient Diagnosis : _____

Special Appointment Requests/Patient Availability

Payment Information

Method of Payment? *(Please Circle)*

Cash MC, Visa American Express Check International Insurance

If the patient has International Insurance please complete the following

Company Name : _____

Address : _____

Tel: _____ Fax: _____

Group Number or Policy Number : _____

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 travelling

Please indicate any special needs the patient might have :

