Penn Medicine

Office of Penn Global Medicine
Suite 210, 3440 Market St.
Philadelphia, PA 19104

INTERNATIONAL PATIENT INTAKE FORM

Required Patient Information

Patient Information:

Last	First	MI

Date of Birth	Age	Gender

Patient's Parent Information:

Mother's First Name	Father's First Name

Permanent Home Address	City	State	Zip	Country

Email	Phone	Cell Phone

Temporary Address (in US)	City	State	Zip

Temporary Phone

Employment Information

Name of Employer	Telephone Number	Occupation

Address	City	State	Zip	Country

Additional Services

Spoken Languages	Written Languages	Which is Preferred?

Do you require a medical interpreter during visits? ❑ Yes ❑ No

Additional Information required

Spiritual Affiliation	Ethnicity	Any special needs we should be aware of?

Referring Physician

Name of Physician	Telephone Number	Fax Number

Address	City	State	Zip	Country

Please attach a copy of your passport

Additional Medical Information
Please tell us what specific medical question you have regarding your condition/care, or what question you would like our specialists to answer:
Do you know what kind of specialist you would like your to see? (It is OK if you do not have this information)
Patient's current diagnosis (if known)

Medical Documentation

Please attach copies of original clinical history and medical records as provided by your healthcare provider.

Radiological, pathological and laboratory reports are required to provide a possible treatment plan. Please note that all reports must be provided in English, any report sent in other languages will not be considered and may delay the review process.

It is important that the name, address, telephone number, and fax number of the hospital/clinic is available at the top of each report.

Payment Information: Please select your method of payment for services to be scheduled at Penn Medicine			
Method of Payment #1 – Self Pay			
❑ **Cash**	❑ Wire Transfer	❑ Check	❑ **Bank Check**
❑ **Mastercard**	❑ Visa	❑ American Express	
Method of Payment #2 - International Insurance **If you have insurance, you must provide us with the following information:**			
Name of the Cardholder		**Date of birth of the Card Holder**	
Policy Number	**Subscribers Name (Last, First Middle)**	**Insurance Company Name**	
Insurance Company Address	City, State, ZIP	**Telephone Number**	
If Insurance is through your employer, please provide following information			
Insurance Company Address	City, State, ZIP	**Telephone Number**	
Please attach copies of the front/back of the insurance cards.			

Please tell us how you learned about Penn Medicine?	
1. **Internet**	❑
2. **Penn Medicine Web site**	❑
3. **Advertisement**	❑
4. **Physician Referral**	❑
5. **Embassy**	❑
6. **Personal Contact**	❑
7. **Other (please tell us)**	❑