CHILDREN'S HOSPITAL
& RESEARCH CENTER OAKLAND

International Adoption Clinic

747 52nd Street, Oakland, CA 94618 - 510-428-3010 - **Fax**: 510-450-5878

Post-Adopt Intake Information

Adoptive Parent(s):

_____ _____

DOB: _____ DOB: _____

SSN: _____ SSN: _____

Address: _____

City:_____ State:_____ County:_____ Zip Code:_____

Telephone numbers:

Name:_____

Home ( ) _____ Cell ( ) _____

Work ( ) _____ Fax ( ) _____

Name:_____

Home ( ) _____ Cell ( ) _____

Work ( ) _____ Fax ( ) _____

E-mail address(es): _____

_____

Adoption agency / organization:_____

_____

How did you learn about the International Adoption Clinic at Children's Hospital & Research Center Oakland?

- ☐ Internet site _____
- ☐ Doctor referral _____
- ☐ Friend referral _____
- ☐ Adoption agency _____
- ☐ Other _____

Insurance Information:
Parents will be asked to pay for evaluations at the time services are provided. Documentation of charges will be available for insurance reimbursement. Some services, such as laboratory fees, may be billed directly through your insurance. Please provide a copy of your insurance card.

Child's name:_____

Also known as (names on adoption records, if applicable):

_____

Child's DOB: _____

Child's birth country: _____ City:_____

Province/region: _____

Date of union with your child: _____ Date of US arrival: _____

Age at entry to out-of-home care: _____ Foster/orphanage care? _____

Name of orphanage(s), if applicable:

_____

Please list approximate length of time your child was in each out-of-home placement:

_____

_____

_____

Pediatrician: _____

Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Please sign and date below to give permission to receive information about your child and to obtain laboratory results ordered by your primary care physician.

Signature: _____ Date: _____