UCSF Benioff Children's Hospitals

UCSF Health

1500 Owens Street, Suite 360
San Francisco, CA 94158
415-353-8489 FAX: 415-353-3672
International@ucsf.edu

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

Address: _____

City/Country/Postal Code: _____

Phone Number: _____

Email: _____

Date of Birth: _____ (Month/Day/Year) Age: _____ Country of Origin: _____ (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 & Issuing Country: _____

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

Preferred Language _____

Interpreter Needed? ☐ Yes ☐ No

Guarantor/ Guardian's name (if patient is under 18 years old):

Guarantor/ Guardian's Date of Birth: _____

Relationship to Patient: _____

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Treatment being sought: (Please provide information)

Patient's Diagnosis:

Preferred Specialist/MD:

Patient Contact (Spouse/ Next of Kin/ Relative)

Name:

Address:

City/ State/

Country: Relation:

Telephone:

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

Insurance Company Name:

Send bills to (claims address):

City/State/Country/Zip:

Telephone #/Contact Person:

Group #:

Subscriber/Policy #:

Authorization #:

Reference#:

Payment Method

- ☐ Cash
- ☐ Wire Transfer
- ☐ Cashiers/Travelers Check/ Check (drawn on U.S. bank account)
- ☐ Insurance (requires a U.S. based third party administrator
- ☐ Embassy Sponsored

Credit Card (Preferred Method)

Visa ☐ Master Card ☐ American Express ☐ Other:

How did you find UCSF?

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