



Global Health Services

Patient Registration Form

Please Fill out and Fax back to: +01 305 668 5586

HAVE YOU SEEN A DOCTOR OR HAD A TEST AT MIAMI CHILDREN'S HOSPITAL? Yes No If so, WHEN? MONTH _____, YEAR _____

Patient Information

PATIENT'S FULL NAME			
BIRTHPLACE	DATE OF BIRTH	AGE	SEX M <input type="checkbox"/> F <input type="checkbox"/>
PERMANENT ADDRESS			
CITY	STATE	ZIP CODE	COUNTRY

Contact Information

MOTHER'S FULL NAME	DATE OF BIRTH	LANGUAGE SPOKEN
FATHER'S FULL NAME	DATE OF BIRTH	LANGUAGE SPOKEN
HOME PHONE NUMBER (COUNTRY CODE) + (AREA CODE) + PHONE NUMBER () + () +	OFFICE PHONE NUMBER (COUNTRY CODE) + (AREA CODE) + PHONE NUMBER () + () +	
CELLULAR PHONE NUMBER (COUNTRY CODE) + (AREA CODE) + PHONE NUMBER () + () +	FAX NUMBER (COUNTRY CODE) + (AREA CODE) + FAX NUMBER () + () +	
E-MAIL ADDRESS		

Medical Information

MEDICAL DIAGNOSIS

Physician Information

CAN WE CONTACT YOUR PHYSICIAN? Yes No

PHYSICIAN NAME	PHONE NUMBER (COUNTRY CODE) + (AREA CODE) + PHONE NUMBER () + () +	
SPECIALTY	E-MAIL ADDRESS	
STREET	CITY	COUNTRY

PLEASE COMPLETE THE BACK OF THIS FORM →

Appointment Information

DATE YOU WOULD LIKE TO SCHEDULE THE MEDICAL APPOINTMENT	PLEASE INDICATE THE REASON FOR YOUR VISIT
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DO YOU HAVE IN MIND A SPECIALIST YOU WOULD LIKE TO SEE AT MIAMI CHILDREN'S HOSPITAL? Yes No

IF SO, WHAT IS THE NAME OF THE SPECIALIST? _____

Travel Information

DO YOU HAVE A VISA TO COME TO MIAMI AND RECEIVE MEDICAL TREATMENT? Yes No

* IF YOU HAVE A VISA, YOU MUST SEND A COPY (PARENT & CHILD) ALONG WITH THE QUESTIONNAIRE IN ORDER TO PROVIDE A MEDICAL APPOINTMENT WITH OUR SPECIALIST.
 * PLEASE ADVISE IF YOU REQUIRE A LETTER CONFIRMING THE APPOINTMENT IN ORDER TO PROCESS THE VISA. ONCE THE MEDICAL INFORMATION IS RECEIVED AND REVIEWED, WE WILL INDICATE THE REQUIRED DEPOSIT THAT WILL NEED TO BE PAID IN FULL PRIOR TO THE PATIENT COMING TO OUR INSTITUTION. PLEASE BE ADVISED, IF THE DEPOSIT INDICATED IS NOT UTILIZED, THE HOSPITAL WILL MAKE THE REIMBURSEMENT ONCE THE PATIENT HAS RETURNED TO HIS OR HER COUNTRY.

DO YOU REQUIRE A LIST OF HOTELS NEAR THE HOSPITAL? <input type="checkbox"/> Yes <input type="checkbox"/> No	TEMPORARY UNITED STATES ADDRESS
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PHONE NUMBER OR FAX WHERE WE COULD COMMUNICATE WITH YOU DURING YOUR STAY
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Emergency Contact Information

NAME OF PERSON TO NOTIFY IN CASE OF EMERGENCY	RELATIONSHIP TO PATIENT
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PHONE NUMBER (COUNTRY CODE) + (AREA CODE) + PHONE NUMBER () + () +	ADDRESS IN COUNTRY
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Insurance/Payment Information

DO YOU HAVE INTERNATIONAL INSURANCE?

YES. IF SO, PLEASE FILL IN THE INSURANCE INFORMATION BELOW

PRIMARY INSURANCE PLAN NAME	GROUP NUMBER	
MEMBER NAME	MEMBER NUMBER	GROUP NAME

NO. *IF YOU DO NOT HAVE INTERNATIONAL INSURANCE, GLOBAL HEALTH SERVICES WILL INFORM YOU OF THE COST ESTIMATE. THIS AMOUNT WILL NEED TO BE PAID IN FULL PRIOR TO THE INITIAL OFFICE VISIT.

FULL NAME OF PERSON RESPONSIBLE FOR THE BILL	DATE DAY/MONTH/YEAR
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I _____, RELATIONSHIP TO PATIENT _____;
 GIVE CONSENT TO MIAMI CHILDREN'S HOSPITAL GLOBAL HEALTH SERVICES TO SHARE MY CHILD'S MEDICAL INFORMATION AMONG ALL PHYSICIANS AND MEDICAL PERSONNEL REQUIRED TO DETERMINE POSSIBLE TREATMENT AND PRICE ESTIMATE.

_____ DAY MONTH YEAR
 _____ / _____ / _____
 SIGNATURE DATE