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: __________ Age: ______ Country of Origin: __________

(Month/Day/Year) (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: ___________