NYU Langone Health

International Patient Intake Form

Please send the completed form to internationalservices@nyulangone.org or fax to (646) 501-5296

Date: ___(month) ___ (day) __ (year)

Patient Information:

Family/ Last Name:	First Name:	Middle Name:
Sex: ☐ Man ☐ Female ☐ Intersex	Date of Birth: ___ (month) ___ (day) __ (year)	Age:
Permanent Address:		
City/State/Postal Code:		Country:
Phone:	Mobile:	Fax:
E-Mail:	Preferred Language:	
Father's Name:	Mother's Name:	
Alternate Contact:	Relationship: (spouse/Parent/Friend/etc.):	
Phone:	Mobile:	Fax:
E-Mail:		

Do you have Medical Insurance (with international benefits/coverage)? ☐ **Yes** ☐ **No** ☐ **Self-Pay**
(If yes, please provide information below and send a copy of the front and back of the insurance card)

Insurance Name: _____ **Policy #**_____

Insurance Contact information: _____

Your Present Problem and Medical History:

Chief Complaint/Current diagnosis:

How long have you experienced current symptom(s)? _____ year/s _____ months

Preferred Doctor and Appointment Date: *(we will make every effort to accommodate your request)*

Is there a specific NYU physician you would like to see? ◯ No ◯ Yes If so, who? _____

When would you like to have an appointment? *Your available dates:* _____	Do you already have a visa for travel to the United States? ◯ YES ◉ NO

Please let us know how you heard about us? ☐ friend/family ☐ internet ☐ my doctor ☐ other_____

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient Signature: _____ Date: _____/_____/_____

Guarantor Signature (if other than the patient): _____ Date: ____/_____/_____