PATIENT INFORMATION/CONSENT-IMMIGRATION PHYSICAL

LEGAL PASSPORT NAME:____
Last First Middle

PLACE OF BIRTH:____
(City/town/village) COUNTRY

SSN#_________________________**ALIEN#**___________________________________

ADDRESS (In USA):____
Street City State

BIRTHDATE:__________________________________ **SEX:** □**MALE** □**FEMALE**

HOME PHONE:_________________**CELL:**_____________________ **WORK PHONE:**_______________

EMPLOYER:_______________________________________ **EMAIL:**___________________________________

IMMIGRATION ATTORNEY____________________________________**PHONE**________________________

PRIMARY CARE PHYSICIAN :_____________________________________ **PHONE:**___________________

Chronic physical, mental Illnesses:____

Do you have any allergies to medication, foods, or environmental? If yes, type_________________________

List vaccines you have had and dates if known including oral or nasal mist:________________________________
____

Current medications (including oral contraceptives or anticoagulants):____________________________________
____

*Any hospitalizations? Yes__No__If yes please list:*____
____

The above information is accurate to my best recollection. I understand that insurance may not cover immigration physical services and I am responsible for all fees associated with this visit. Excel Pediatrics and Family Care will not file with health insurance for Immigration Physical. I understand I will receive documentation of all vaccines received and am responsible for keeping the record in a safe place and up-to-date. Payment is due at the time of service by cash, visa or mastercard.

Patient/Parent/Guardian Signature:____ **Date:**__________