JUPITER MEDICAL CENTER
Global Medicine Program
Your health, our expertise.

Today's Date: …….

Patient Information

Family Name ……First Name ……Middle Name(s) ……

Birthdate (mm/dd/yy) …… Sex (M/F) ……Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Religion (Optional) ……..

Patient's Phone # in U.S. …… Fax No. in U.S. …….. Cell Phone …….

Mailing or Permanent Address……
(Street Number/Name/City/Region/Country/Zip Code)

Address in U.S. …… Birthplace ……..
(Street Number/Name)

…… Citizenship ……
(City/Zip Code)

Home Country Address …… ……
(Street Number/Street Name/Region/Zip Code) (City Name/Zip Code, Country)

Email …….. Home Phone ……
(Country Code/City Code/Phone No.)

Occupation …….. Work Phone …… Fax ……..
(Country Code/City Code/Ph#) (Country Code/City Code/Ph#)

Employer Name ……

Employer Address ……..

Name of Spouse or Name of Parent if Patient is a Child

Name …….. Birthdate (mm/dd/yy)……

Home Phone # in U.S. …….. Email: ……..

Relationship to Patient ……..

Mailing or Permanent Address ……..

Occupation …… Employer Name ……

Employment Status ☐Full Time ☐Part Time ☐Student Work Number ……

Name of Contact in the United States (Other than Patient) / Person to Contact in Case of Emergency or for Issues Concerning the Patient after Treatment/Surgery

Name …….. Phone # in U.S. …….. Fax# ……..

Address/Email …….. Relationship to Patient ……

Name of Patient's Physician in Home Country (With Whom JMC Can Communicate)

Name ……..

Phone Number# …….. Fax# ……..

Address/Email …….. Medical Specialty ……

Medical Insurance Information

Do you have Medical Insurance (with international benefits/coverage)? ☐ Yes ☐ No

(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 ……

(If no, please provide information below)

Person Responsible for the Bill: ……

Permanent Address: …… **City:**……..

Country:…… **Relationship to Patient:** ……

Chief Medical Complaints/Current Symptoms and Medical History

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Is your condition related to an accident? ☐ Yes ☐ No A Sports Injury? ☐ Yes ☐ No Date of Injury?……..

Describe briefly ……

Do you have Pain? ☐ Yes ☐ No If yes, where does it hurt? ……..

Does the pain radiate to other areas? ☐ Yes ☐ No If yes, where? ……

Do you have Numbness/tingling? ☐ Yes ☐ No If yes, where? ……

Do you have Stiffness? ☐ Yes ☐ No If yes, where? ……

Do you have Swelling? ☐ Yes ☐ No If yes, where? ……

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

Has your physician recommended surgery? ☐ Yes ☐ No ☐ Have not seen a physician for this problem

Chief Medical Complaints/Current Symptoms and Medical History (Cont'd)

Are you presently taking any pain medications for this problem? ☐ Yes ☐ No

If yes, please note:

Medication Name	Dose	Frequency
……	……	……
……	……	……
……	……	……
……	……	……

Have you tried alternate treatment (other than surgery)? ☐ Yes ☐ No **If Yes, please describe:**

Physical Therapy (how long?) ……

Injection? What type …… How many times? ……

Others? What type …… How many times? ……

Are you presently using orthotics such as a cast, brace, splint, etc.? ☐ Yes ☐ No

If yes, what type and for how long? ……

Any other medical conditions? (past or present) Please list:

……

……

Preferred Physician and Appointment Date
(we will make every effort to accommodate your request)

Is there a specific JMC physician you would like to see? ☐ Yes ☐ No If so, who? ……

What are your available dates for an appointment? ……

Do you and your escort(s) currently have a visa for travel to the United States? ☐ Yes ☐ No ☐ Not needed

Will you require an interpreter for your visits? ☐ Yes ☐ No If yes, what language? ……

Will you require assistance to coordinate your travel and accommodation arrangements? ☐ Yes ☐ No

How did you hear about JMC? ☐ Family/Friend ☐ Internet ☐ My Physician ☐ Embassy ☐ Event ☐ Insurance

Important Reminders

Please fax, email or mail copies (<u>please DO NOT send originals</u>) of the documents listed on the attached "Required Documents Checklist" to:

Jupiter Medical Center
Attn: Patient Coordinator, Global Medicine Services
1210 So. Old Dixie Highway, Jupiter, FL 33458
Office: (561) 263-5050 • Fax: (561) 263-0458 • Email: Global.Medicine@jupitermed.com