MedStar Georgetown University Hospital

MedStar Georgetown University Hospital
International Services

3800 Reservoir Rd., NW
CCC Bldg., Room 3402
Washington, D.C 20007
Phone: 202-444-1588 **Fax:** 202-444-06-06
International@gunet.georgetown.edu

Patient Information and Registration Form (*indicated required information)

Family Name*:_____ First Name:*_____Middle Initial:_____

Address*:_____
City/Country/Post Code*:_____
Phone/Cell/Mobile*:_____
Email*:_____
Date of Birth*:_____ Age:_____ Place Of Birth:_____
(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: _____

Marital Status*:____Single ____Married ____Divorced ____Widowed ____Legally Separated
____Registered Domestic Partner(RDP) ____RDP-Dissolved
Preferred Language*:_____
Interpreter Needed*?_____Yes _____No

Occupation (parent, if minor):_____
Length of Employment:_____
Employer's Name:_____
Address:_____
City/State, Country:_____
Telephone:_____
Email:_____

Emergency Contact: (Spouse/Next of Kin/Relative)

Name:_____
Address:_____
City/State, Country:_____
Relation:_____
Telephone:_____

Local Contact Information: (Contact after arrival)

Name:_____
Address:_____
City/State, Country:_____
Relation:_____
Telephone:_____

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Treatment being sought: (Please provide Information and Medical Records):
Patient's Diagnosis:_____
Preferred Specialist/MD:_____

Payment Method: ___Cash ___Cahiers/Traveler's Check/Check (Draw on U.S. Bank Account)
___Wire Transfer ___International Insurance (Requires a U.S.-based 3rd party administration)
Credit Card (Preferred Method)
___Visa___ MasterCard ___American Express____ Other:_____

If your insurance approved treatment and will pay for all costs, please provide:
Insurance Company Name:_____
Send bills to (Claim Address): _____
City, State/Country/Zip:_____
Telephone#/Contact Phone:_____

Group #:_____ Subscriber/Policy#:_____
Authorization#:_____ Reference #:_____

How did you hear about MGUH?
___Friend/Family ____Physician Referral _____Internet search/MGUH Website _____Reputation
___Other:_____