

**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](mailto: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*:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Nationality*:	_____
Religion:	_____		
Ethnicity :	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown/Declined		
Race:	<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American		
	<input type="checkbox"/> Native Hawaiian/ Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> White or Caucasian <input type="checkbox"/> Unknown/Declined		
U.S. Social Security Number (If Applicable):	_____		
Passport Identification Number:	_____		
Marital Status*:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated		
	<input type="checkbox"/> Registered Domestic Partner(RDP) <input type="checkbox"/> RDP-Dissolved		
Preferred Language*:	_____		
Interpreter Needed*?:	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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

Emergency Contact: (Spouse/Next of Kin/Relative)	Local Contact Information: (Contact after arrival)
Name: _____	Name: _____
Address: _____	Address: _____
City/State, Country: _____	City/State, Country: _____
Relation: _____	Relation: _____
Telephone: _____	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 3<sup>rd</sup> 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: \_\_\_\_\_