Nicklaus Children's Hospital

Global Health

Patient Registration Form

Please Fill out and Fax back to: +01 305 668 5586

Have you seen a Doctor or had a test at Nicklaus Children's Hospital? ☐ Yes ☐ No If so, when? Month __________, Year __________

Contact Information

Patient's Full Name			
Primary Lenguage	Date of Birth	Age	Sex M ☐ F ☐
Permanent Address			
City	State	Zip Code	Country

Contact Information

Mother's Full Name	Date of Birth	Phone Number
Father's Full Name	Date of Birth	Phone Number

Home Phone Number (country code) + (area code) + phone number ( ) + ( ) +	Phone Number in Miami
Cellular Phone Number (country code) + (area code) + phone number ( ) + ( ) +	Address in Miami
Mother's E-mail Address	Father's E-mail Address

Medical Information

Medical Diagnosis

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Physician Information

Can we contact your physician? ☐ Yes ☐ No

Physician Name	Phone Number (country code) + (area code) + phone number ( ) + ( ) +	
Specialty	E-mail Address	
Street	City	Country

Please complete the back of this form →

Appointment Information

Date you would like to schedule the medical appointment

Do you have in mind a Specialist you would like to see at Nicklaus Children's Hospital? ❑ Yes ❑ No

If so, what is the name of the Specialist?____

Travel Information

Do you have a Visa to come to Miami and receive medical treatment? ❑ Yes ❑ No ❑ N/A

* If you have a visa, you must send a copy (parent & child) along with the questionnaire in order to provide a medical appointment with our specialist.
* Please advise if you require a letter confirming the appointment in order to process the Visa. Once the medical information is received and reviewed, we will indicate the required deposit that will need to be paid in full prior to the patient coming to our institution. Please be advised, if the deposit indicated is not utilized, the hospital will make the reimbursement once the patient has returned to his or her country.

Do you require a list of hotels near the Hospital? ❑ Yes ❑ No	Temporary United States Address
Phone number where we could communicate with you during your stay in the U.S	

TeleHealth

Would you be interested in a video conference (TeleHealth) with one of our specialists? (*Physician in home country required for consult*):

❑ Yes ❑ No

Insurance/Payment Information

Do you have International Insurance?

❑ Yes. If so, Please Fill In the Insurance Information Below

Primary Insurance Plan Name	Group Number	
Member Name	Member Number	Group Name

❑ No. *If you do not have International Insurance, Global Health Services will inform you of the cost estimate. This amount will need to be paid in full prior to the initial office visit.

Full Name of Person Responsible for the Bill	Date day/month/year

I ____, relationship to patient ____;
Give consent to Miami Children's Hospital Global Health Services to share my child's medical information among all physicians and medical personnel required to determine possible treatment and price estimate.

DAY MONTH YEAR

____ __________/_______________/____________

Signature Date