Report of Medical Examination and Vaccination Record

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-693
OMB No. 1615-0033
Expires 03/31/2017

► **START HERE - Type or print in black ink.**

Part 1. Information About You (To be completed by the person requesting a medical examination, **NOT** the civil surgeon)

1. Name
   Family Name (Last Name) | Given Name (First Name) | Middle Name

2. Home Address
   Street Number and Name | Apt. Ste. Flr. ☐ ☐ ☐ | Number
   City or Town | State | ZIP Code

3. Gender ☐ Male ☐ Female

4. Daytime Telephone Number

5. Mobile Telephone Number (if any)

6. Email Address (if any)

7. Date of Birth (mm/dd/yyyy)

8. City/Town/Village of Birth

9. Country of Birth

10. Alien Registration Number (A-Number) (if any)
    ► A-

Applicant's Certification

I certify, under penalty of perjury, that I am the person who is identified in **Part 1.** of this Form I-693, and that the information in **Part 1.** of this benefit request is complete, true, and correct. I understand the purpose of this medical examination, and I authorize the required tests and procedures to be completed. If it is determined that I willfully misrepresented a material fact or provided false or altered information or documents with regard to my medical examination, I understand that any immigration benefit I derived from this medical examination may be revoked, that I may be removed from the United States, and that I may be subject to civil or criminal penalties.

NOTE: Select the box for either **Item Number 11. or 12.**

11. ☐ I can read and understand English, and have read and understand every question and instruction in **Part 1.** of this Form I-693, as well as my answer to every question in **Part 1.** I have read and understand the above **Applicant's Certification**.

12. ☐ The interpreter named in **Part 2.** has read to me every question and instruction in **Part 1.** of this Form I-693, as well as my answer to every question in **Part 1.**, in _____, a language in which I am fluent. I understand every question and instruction in **Part 1.** of this Form I-693 as translated to me by my interpreter, and have provided complete, true, and correct responses in the language indicated above. The interpreter named in **Part 2.** also has read the above **Applicant's Certification** to me, in a language in which I am fluent, and I understand the **Applicant's Certification** as read to me by my interpreter.

Applicant's Signature

13. **Signature - Do not sign or date Form I-693 until instructed to do so by the civil surgeon** **Date of Signature** (mm/dd/yyyy)

PATIENT INFORMATION FORM

To allow us to improve our service to you, we are asking all patients to complete an updated patient form. Please complete the **entire** form and return to the front desk before your visit.

Name: _____ _____ _____

First *M.I.* *Last*

Street Address: _____ *Unit #:* _____

City: _____ *State:* _____ *Zip:* _____

Date of Birth _____ *Sex* _____ *S.S #* _____

Home Phone Number: _____ *Cell Phone Number:* _____ *(reminders sent electronically)*

Email Address: (reminders sent electronically) _____

Ethnicity (Circle One): Hispanic / Non-Hispanic

Preferred Language: English / Other (Please specify): _____

Race (Circle one): African American / Asian / Caucasion / Native American / Other

Emergency Contact: _____ ***Phone:*** _____

Past Medical History:

__Alcoholism	__Bleeding Disorder	__Epilepsy	__Kidney Disorder	__Rheumatic Fever
__Allergies	__Blood Disease	__Glaucoma	__Liver Disorder	__Skin Disorder
__Anemia	__Blood Transfusion	__Gout	__Lung Disease	__Stomach Ulcer
__Anxiety Disorder	__Cancer	__Heart Disease	__Measles	__Substance Abuse
__Arthritis	__Diabetes	__Hepatitis A, B or C	__Migraines	__Stroke
__Asthma	__Depression	__High Blood Pressure	__Osteoporosis	__Thyroid Disorder
__AIDS/HIV	__Ear Problems	__High Cholesterol	__Pneumonia	__Tuberculosis
__Back Problems	__Eating Disorder	__Joint Disorder	__Polio	__Venereal Disease

Hospitalizations & Surgeries:

Reason: _____ *Date:* _____

Reason: _____ *Date:* _____

Reason: _____ *Date:* _____

Family History: *Has anyone in your family ever had any of the following conditions:*

__Alcoholism	__Asthma	__Diabetes	__High Cholesterol	__Migraines
__Allergies	__AID/HIV	__Epilepsy	__High Blood Pressure	__Psychiatric Dis
__Alzheimer's	__Bleeding Disorder	__Genetic Disorder	__Joint Disorder	__Osteoporosis
__Anemia	__Blood Disorder	__Glaucoma	__Kidney Disease	__Stroke
__Anxiety	__Cancer	__Heart Disease	__Liver Disorder	__Substance Abuse
__Arthritis	__Depression	__Hepatitis	__Lung Disease	__Thyroid Disorder

Details: _____

_____

Smoker? *[ ]no [ ]yes How much?* _____

Alcohol use? *[ ]social [ ] moderate [ ] heavy*

Current Medications: *What medications are you currently taking?*

Name _____ *Dosage* _____ *Frequency* _____

Name _____ *Dosage* _____ *Frequency* _____

Name _____ *Dosage* _____ *Frequency* _____

Name _____ *Dosage* _____ *Frequency* _____

Name _____ *Dosage* _____ *Frequency* _____

Allergies: *Are you allergic to any of the following?*

__Adhesive Tape	__Antibiotics	__Aspirin	__Barbiturates (sleeping pills)
__Codeine	__Iodine	__Latex	__Local Anesthetics __Sulpha

Do you have any other allergies?

Name _____ *Reaction* _____

Name _____ *Reaction* _____

Name _____ *Reaction* _____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Who else do you allow to have access to your health information? What is their relationship to you?

Name_____ Relationship_____Phone #_____

Name_____ Relationship_____Phone #_____

Today's Date: _____

Print Patient Name: _____

Patient Signature: _____

Or

Parent/Guardian (for patients under 18)_____

Print Name: _____

Signature: _____

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