Mount Sinai

International Patient Services

Patient Information Form		
Last/Family Name:	First:	Middle:
Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss	Age:	Date of Brith (Month/Day/Year):
Primary Language	Patient Gender: ☐ Male ☐ Female	Have you previously been a patient? ☐ Yes ☐ No
Address of Permanent Residence:		Country:
City:	State/Province:	Postal Code:
Home Phone:	Mobile:	Email:
Mother's Name:	Father's Name:	Fax:
Referring Physician:	Phone:	Physician Email:
Travel Dates/Length of Stay in New York	Have you Obtained a Visa? ☐ Yes ☐ No	How did you learn about us? ☐ Phyisican ☐ Family/Friend ☐ Govrnement ☐ Insurance ☐ MSHS Physician ☐ Print/TV/Radio ☐ Internet ☐ MSHS Reputation
Diagnosis and or Requested Treatment:		
Method of Patment (If you have insurance, please provide details below):		
Insurance Name:	Subscriber's Name:	Group No:
Policy Number:	Insurance Address	
Insurance Phone:	Insurance Fax:	Insurance Email:
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Mount Sinai Hospital International Patient Services or insurance company to release any information required to process my claims. By providing e-mail addresses, I allow correspondences regarding care to be communicated via email.		
Patient/Guardian Signature:		Date

Mount Sinai

CONSENT for COMMUNICATION via E-MAIL

(Provider-Patient)

I, _____, hereby consent to have my physician, _____, communicate with me or members of his staff, where appropriate or other physicians, nurse practitioners and pharmacists via e-mailing regarding the following aspects of my medical care and treatment: [test results, prescriptions, appointments, billing, etc.]. I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mail communications between my physician and me or members of my physician's office staff, or between my physician and other physicians, nurse practitioners and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail communications between my physician and me or members of his office staff, or between my physician and other physicians, nurse practitioners or pharmacists regarding my medical care and treatment will be printed out and made a part of my medical record. I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e-mail.

Signature _____ Date _____