

IMMIGRATION EXAMINATION-PATIENT INFORMATION

Please print clearly. This information must EXACTLY match all papers filed with USCIS.

PATIENT NAME: _____ DATE: ____/____/____
(Last) (First - No Nicknames) (Middle) MM DD YYYY

HOME ADDRESS: _____
(Street) (City) (State) (Zip Code)

HOME PHONE: _____ CELL PHONE: _____

A NUMBER: _____ U.S. Social Security #(if any) _____
If unknown please leave blank (optional)

DATE OF BIRTH: ____/____/____ AGE: _____ **Gender:** Male Female
MM DD YYYY

Have you done this exam before? YES NO Are you a refugee? YES NO

COUNTRY OF BIRTH: _____ CITY OF BIRTH: _____

PAYMENT AGREEMENT

I understand that I (or my minor child) am here for the USCIS medical examination and that I am fully responsible for the cost of this exam. I understand that Manassas Clinical Research Center will not accept assignment for this exam from any insurance company, or other agency. The cost of this exam is fully my responsibility. I understand that the fee is due and payable at the time of the exam. I certify that I understand the purpose of the medical examination; I authorize the required tests to be completed.

Patient Signature *(or Guardian if patient is a minor)* **Date** **Print Name** *(and relation if other than patient)*

HIPPA

By signing below I acknowledge I have reviewed a copy of the Notice of Privacy Practice today while in the office and I understand and agree to its terms. I may obtain a copy of this Notice for my records at any time by request.

Patient Signature *(or Guardian if patient is a minor)* **Date** **Print Name** *(and relation if other than patient)*

IF PATIENT IS A MINOR (less than 18 years old)

PARENT NAME: _____ RELATION: _____
(Last) (First - No Nicknames) (Middle)

OFFICE USE ONLY

Height: _____ Weight: _____ BP: _____ Pulse: _____ Allergies: _____

____ RPR _____ MMR Titer _____ pt brought records Pregnant Weeks: _____

____ VZ Titer _____ PPD _____ BY: _____ Date: _____ Send for Chest X-ray

____ MMR MERCK LOT: _____ EXP: _____ Location: _____ BY: _____ Date: _____

____ TD Mass Bio LOT: _____ EXP: _____ Location: _____ BY: _____ Date: _____

____ PPD Aventis LOT: _____ EXP: _____ Location: _____ BY: _____ Date: _____

____ VZ MERCK LOT: _____ EXP: _____ Location: _____ BY: _____ Date: _____

____ Hep B MERCK LOT: _____ EXP: _____ Location: _____ BY: _____ Date: _____

____ MCV4 SANOFI LOT: _____ EXP: _____ Location: _____ BY: _____ Date: _____

____ TDaP SANOFI LOT: _____ EXP: _____ Location: _____ BY: _____ Date: _____

____ PPV MERCK LOT: _____ EXP: _____ Location: _____ BY: _____ Date: _____

____ Influenza _____ LOT: _____ EXP: _____ Location: _____ BY: _____ Date: _____