PATIENT INFORMATION- PLEASE PRINT CLEARLY

Patient's name:

Last First Middle

Gender:	Date of birth: mm/dd/yyyy
Social security no:	Passport no:
Alien Registration Number: (if any)	Email address:

Single [ ] Divorced[ ] Widowed [ ] Married [ ]

Spouse's name, if married:

Place of Birth (city, state):		Country of birth:
Phone no:		Alternate no:
Address:		
City:	State:	Zip:

Parent's name (if under 18 year-old):
Father: Mother:

Employed by (firm name):
Address:

Referral by:

Cash Only for Immigration Medical Exam:
I understand that my office visits and lab works are for immigration purpose, and any fee or expense incurred will solely responsible myself. Dr. Liu's office **will not** be responsible for filing or involved in insurance filing in any shape or form.

I certified above provided information is true. **Please make sure all information provided is correct.**
Dr. Liu's office **will not** able to alter or change any information after the exam process has started.

Patient's signature (parent or guardian if minor): Date: