ELITE MEDICAL CLINIC

PATIENT INFORMATION
IMMIGRATION PHYSICAL

DATE: _____

LEGAL PASSPORT NAME: _____
Last First Middle

ADDRESS: _____

City: _____ State: _____ Zip: _____

CELL PHONE: _____ HOME PHONE: _____

E-MAIL: _____ AGE: _____

DATE OF BIRTH: _____-_____-_____ SEX: Male / Female MARITAL STATUS: Married Single Other

CITY OF BIRTH: _____ COUNTRY OF BIRTH: _____

SOCIAL SECURITY #: _____-_____-_____ ALIEN #: _____

DRIVER'S LICENSE #: _____ PASSPORT #: _____

Immigration Attorney _____ Phone Number _____

Emergency Contact: _____ Phone: _____ Relation _____

Past Medical Illness(es): _____

Chronic Physical Illness(es): ❑ NO ❑ YES _____

Chronic Mental Illness(es): ❑ NO ❑ YES _____

Current Medication(s): ❑ NO ❑ YES _____

Do you have any allergies to medication? ❑ NO ❑ YES Please explain: _____

Do you have **any allergies to a vaccine** in the past? ❑ NO ❑ YES Please explain: _____

Do you have **any allergies to food** such as eggs? ❑ NO ❑ YES Please explain: _____

Do you have **any cough, night sweats, abnormal weight loss**? ❑ NO ❑ YES Please explain: _____

Do you have **psychiatric issues, homicidal thoughts, etc**? ❑ NO ❑YES Please explain: _____

Are you pregnant now or is there a possibility you are pregnant? ❑ NO ❑ YES

List all vaccines you have had and dates (Vaccination record required): _____

_____

The above information is accurate to my best recollection. I am responsible for all fees associated with the visit. Payment is due at the time of service.

Patient/Parent/Guardian Signature _____ Date _____

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 02/28/2019

▶ **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. **Your Full Name**

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

2. **Physical Address**

Street Number and Name | Apt. Ste. Flr. Number

City or Town | State | ZIP Code

3. **Other Information**

A. Sex ☐ Male ☐ Female

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

C. City/Town/Village of Birth

D. Country of Birth

E. Alien Registration Number (A-Number) (if any)
▶ **A-**

F. USCIS Online Account Number (if any)
▶

Part 2. Applicant's Statement, Contact Information, Certification, and Signature

NOTE: Read the **Penalties** section of the Form I-693 Instructions before completing this Part. You must submit Form I-693 in a sealed envelope to USCIS as directed in the Form I-693 Instructions.

Applicant's Statement

NOTE: Select the box for either **Item A.** or **B.** in **Item Number 1.**

1. Applicant's Statement Regarding the Interpreter

A. ☐ I can read and understand English, and I have read and understand every question and instruction on this form and my answer to every question.

B. ☐ The interpreter named in **Part 3.** read to me every question and instruction on this form and my answer to every question in _____, a language in which I am fluent, and I understood everything.

Applicant's Contact Information

2. Applicant's Daytime Telephone Number

3. Applicant's Mobile Telephone Number (if any)

4. Applicant's Email Address (if any)