MAKING AN APPOINTMENT

To make it easier to arrange an appointment at the Sírio-Libanês Hospital, just fill out the following form. If you have any queries, contact the team at the International Patient Service Center.

PATIENT DETAILS

IDENTIFICATION

Full name*:

ID*:

Type*:   RG

             RNE

             Passport

             Other:

CPF (for Brazilians and residents)**:**

Sex*:   Female

             Male

Date of birth* (mm/dd/yyyy)**:**

/   /

HOSPITAL SÍRIO·LIBANÊS

Country of citizenship:

Father's name*:

Mother's name*:

Marital status*:

Single

Married

Separated

Divorced

Widowed

Profession*:

ADDRESS

Address*:

Number*:

Unit:

District:

City*:

State:

Postal Code:

Country*:

PHONE NUMBERS AND EMAIL ADDRESS

Home phone*:   Cell phone*:   Business phone:

Email address*:

DETAILS OF THE PERSON RESPONSIBLE FOR THE PATIENT

IDENTIFICATION

Full name*:

ID*:

Type*:
     RG

     RNE

     Passport

     Other:

CPF (for Brazilians and residents):

Sex*:
     Female

     Male

Date of birth* (mm/dd/yyyy):

| /   / |

Country of citizenship:

| |

Father's name*:

| |

Mother's name*:

| |

Marital status*: Single

  Married

  Separated

  Divorced

  Widowed

Profession*:

| |

Relationship to the patient*:

| |

ADDRESS

Address*:   **Number*:**

| | | |

Unit: **District:**

| | | |

City*:

State:

Postal Code:

Country*:

PHONE NUMBERS AND EMAIL ADDRESS

Home phone*:

Cell phone*:

Business phone:

Email address*:

* These fields must be completed

PHYSICIAN OF CHOICE AT SÍRIO-LIBANÊS HOSPITAL

Name of physician*:

Best date for an appointment* (mm/dd/yyyy):

/   /

INFORMATION ON YOUR CONDITION

Diagnosis*:

Patient undergoing treatment*:

No

Yes

If so, give details of the physician in charge:

Name:

Phone Number:

Email address:

Are you looking for a second opinion?*

No

Yes

NEEDS

What is the purpose of this request?*

Appointment with a specialist

Hospitalization

HEALTH INSURANCE

Does your health plan cover hospital expenses?*

No/I do not have one

Yes

If so, please give the name of your insurance company:

* These fields must be completed