

# Medical Tourism Visitor Medical Information Declaration Form

Full Name

Passport Number

Nationality

Date of Birth

Contact Number

Email Address

Home Address

Purpose of Visit (Medical Procedure)

Hospital/Clinic Name (Destination)

Travel Dates

Arrival

Departure

Emergency Contact Name

Relationship

Emergency Contact Number

Existing Medical Conditions

Allergies

Medications

Recent Surgeries/Treatments

Vaccination History

Physician's Name & Contact

Insurance Provider

Policy Number

Declaration & Consent

☐ I hereby declare that the above information is accurate and complete to the best of my knowledge.