Medical Tourism Form

Patient name: ____ Age: __________

Date of birth (m/d/y): ______/_______/________ Home #: (_______)_________________ Other #: (_______)_________________

SS#: _________________________ Hotel: _______________________ E-mail address: ____________________________________

Home address: ____

___________________________Passport #: _______________________________________Zip Code: ________________________

- I agree to have anonymous real time updates on IMTC social media pages Yes__________ No__________

Emergency contact person in your home country:

Name: ____ (relation): ________________________

Home #: (_______)_________________ Other #: (_______)_________________E-mail: ___________________________________

Emergency contact person in situ:

Name: ____ (relation): ________________________

Home #: (_______)_________________ Other #: (_______)_________________E-mail: ___________________________________

I understand that any treatment for complications; additional medical procedures, change of procedure, additional services, extended hospital stay or additional medical supplies will be charged extra. In the event that any of the above occurs I hereby authorize Medical Tours Costa Rica to charge my credit card for these costs.

Credit Card #: ____ Type: _________________________ Exp. Date: __________

I, ____ understand and am in agreement with the above Information.

An impression of the debit card is required.

Signature: _______________________________

Date: ___________________________________

ID: ____