Operation Smile UAE

# Initial Patient Contact Information Sheet

| **Patient Full Name:** | |
|---|---|
| **Patient Date of Birth:** / / | **Patient Sex:** **Male** **Female** |
| **Patient Address/Emirate:** | |
| **Patient Nationality:** | **Date of Initial Contact:** / / |
| **Who has made initial contact to OS UAE:** | |
| **Parent/Guardian full names** (*applicable for child patients only*):<br>**Mother:**<br>**Father:** | |
| **Contact Email:** | **Contact Phone Number:** |
| **Brief History:** | |
| **Does the patient have medical insurance?**<br>***If yes, Name of insurance provider and is treatment covered?***<br><br>**Please list other charities from which you are seeking assistance:** | |
| **Employer and Monthly Income:**<br>**Patient** ***(applicable for adult patients only):***<br>**Mother** (***applicable for child patients only***):<br>**Father** (***applicable for child patients only***): | |
| **Household Size** (*number of family members in your home for whom you are responsible*): | |
| **Notes:** | |
| **Please send as attachments the following documents, if available:**<br>Facial photograph of patient<br>Close up of Cleft Lip and/or Palate, *if possible*<br>Hospital Discharge or Medical Reports | Emirates ID copies for child and parents<br>Passport copies for child and parents |

Please complete as fully as you can, and return to: patients@operationsmileuae.ae

**Thank you.**