

International Pediatric Health Services Review Intake Form

First and Last Name(s) of Parent(s): _____

Date of Birth: __/__/__

Child's Name: _____

Date of Birth: __/__/__

Gender: M [] F []

Address: _____

City: _____ State _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Email Address: _____

Child's Country of Origin: _____

Adoption Agency: _____

Adoption Agency Phone Contact: _____

Adoption Agency Contact's e-mail address: _____

Will you be sending us an actual pre-adoption medical before going abroad?

Yes []

No []

Would you like to receive information from the Worldwide Orphans Foundation?

Yes []

No []

Payment:

Payment Amount: _____

Please see website for current fee schedule (<http://www.orphandoctor.com/services/feeschedule.html>)

Credit Card Information:

Visa: _____

Mastercard: _____

Name as it appears on card: _____

Exp. Date: _____

I, _____ (PRINT NAME), hereby give consent for Dr. Jane Aronson to share her pre-adoption assessment with my agency/attorney.

_____/_____/_____
(MONTH/DAY/YEAR)

(YOUR SIGNATURE)

The information and records obtained during the pre-adoption process may be incomplete and/or inaccurate. I act as an interpreter of these records and it must be understood that the review process and assessment does not guarantee that the child will be healthy.

Signature of Understanding: _____

Please mail or fax to:
338 East 30th Street, #1R
New York, NY 10016
FAX: 212.207.6665