

| PATIENT INFORMATION FOR I-693 APPLICATION | |
|--|---|
| LAST NAME: | |
| FIRST NAME: | DATE OF BIRTH: |
| MIDDLE NAME: | CHECK BOX - MALE OR FEMALE MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> |
| STREET ADDRESS: | |
| CITY: | STATE: |
| ZIP CODE: | |
| PHONE NUMBER: | EMAIL ADDRESS: |
| INTERPRETER'S INFORMATION REQUIRED (IF ACCOMPANYING APPLICANT AT USCIS INTERVIEW): | |
| LANGUAGE INTERPRETING: | |
| FIRST AND LAST NAME: | |
| COMPLETE MAILING ADDRESS: | |
| PHONE NUMBER AND EMAIL: | |
| PROVIDE BOTH COUNTRY OF BIRTH AND CITY/PLACE OF BIRTH: | |
| COUNTRY: | CITY/TOWN: |
| ALIEN REGISTRATION NUMBER (if any) A _ _ _ _ _ | |
| USCIS Online Account Number (if any) _ _ _ _ _ | |
| PROVIDE <u>ALL</u> INFORMATON FOR <u>ONE</u> OF THE THREE ITEMS BELOW FOR OFFICIAL IDENTIFICATION: | |
| (1) DRIVER'S LICENSE <u>NUMBER</u> , <u>STATE</u> , and <u>EXPIRATION DATE</u> : | |
| (2) PASSPORT <u>NUMBER</u> , <u>COUNTRY</u> , and <u>EXPIRATION DATE</u> : | |
| (3) IDENTIFICATION <u>NUMBER</u> , <u>STATE</u> , and <u>EXPIRATION DATE</u> : | |
| MEDICAL HISTORY & CURRENT MEDICATIONS: | |
| HISTORY OF POSITIVE PPD (TB/Tuberculosis) Screening: YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE <input type="checkbox"/> | |
| ARE YOU PREGNANT: YES <input type="checkbox"/> NO <input type="checkbox"/> HAVE YOU HAD CHICKEN POX: YES <input type="checkbox"/> NO <input type="checkbox"/> HAD VACCINE <input type="checkbox"/> | |