

PATIENT INFORMATION FOR I-693 APPLICATION	
LAST NAME:	DATE OF APPOINTMENT:
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 ALL INFORMATION FOR ONE 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"/>	