Emergency Contact and Medical Form

PATIENT NAME: _____ BIRTH DATE: _____

EMERGENCY CONTACT NAME: _____ HOME PHONE NUMBER: _____

EMERGENCY CONTACT ADDRESS: _____ WORK PHONE NUMBER: _____

_____ CELL PHONE NUMBER: _____

Additional Contact Name: _____ Home Phone Number: _____

Additional Contact Address: _____ Work Phone Number: _____

_____ Cell Phone Number: _____

Primary Physician Name: _____ Office Phone Number: _____

Secondary Physician Name: _____ Office Phone Number: _____

Additional Physician Name: _____ Office Phone Number: _____

Health Insurance Company Name: _____ Member #: _____

Long Term Care Insurance Name: _____ Member #: _____

Medicare #: _____ Medicaid #: _____

Blood Type: _____ Uses tobacco? ☐ YES ☐ NO

Religious Beliefs: _____ Drinks alcohol? ☐ YES ☐ NO

Emergency Contact and Medical Form

Current Medications: _____

_____

_____

Allergies and Drug Sensitivities: _____

Medical Conditions: _____

_____

Prior Surgeries: _____

_____

Other Medical Information: _____

Health Care Proxy Name: _____ Home Phone Number: _____

Health Care Proxy Address: _____ Work Phone Number: _____

_____ Cell Phone Number: _____

End of Life Preferences _____ Is a do not resuscitate order in effect? ☐ YES ☐ NO

Advance Directives: _____

Document Location: _____

_____

Police Phone Number: _____ Fire Station Phone Number: _____

Hospital Phone Number: _____ Pharmacy Phone Number: _____