MEDICAL INFORMATION FORM

First Name: _____

Middle Initial: _____

Last Name: _____

Date of Birth: _____
mm/dd/yyyy

Address: _____

City/State/Zip: _____

Phone #: _____

Cell #: _____

Emergency Contact Person and Relationship:
_____
Relationship: _____
Contact Information: _____

Physician's name and office phone #:
_____

Insurance Provider: _____
Insurance Policy #: _____

Preferred Hospital: _____

Existing Medical Conditions

Medical Conditions/Medical Devices (e.g. Coronary Artery Disease, Pacemaker, Diabetic, etc...)

List Primary Conditions/History

1.
2.
3.
4.
5.
6.

List Medications/Supplements

(e.g. Altace 2.5mg 1XDay, etc.)

Drug Name	Dosage	Frequency
Drug Name	Dosage	Frequency
Drug Name	Dosage	Frequency
Drug Name	Dosage	Frequency
Drug Name	Dosage	Frequency
Drug Name	Dosage	Frequency
Drug Name	Dosage	Frequency
Drug Name	Dosage	Frequency
Drug Name	Dosage	Frequency

Allergies / Other Info.

Medications / Anything to which you are allergic

Allergies (e.g. Penicillin, Bee Stings) Other Info.(e.g. Organ Donor, Living Will, Consent to treat, etc)

1. 2.
3. 4.
5. 6.

Authorization for Emergency Medical Treatment:

I, _____, understand that in the case of an illness or injury all efforts will be made to notify the person(s) I have listed as Emergency Contact. In the case of a medical emergency if my Emergency Contact cannot be located, I give permission for transportation, whether by ambulance or otherwise, to a proper medical facility where emergency medical treatment would normally be administered, including but limited to an emergency room, a doctor's office, or medical clinic and I give my permission for medical or surgical treatment as is required in the judgment of medical authorities at the facility.

Signed: _____

Dated: _____