EMERGENCY MEDICAL INFORMATION

FIRST MIDDLE LAST NAME

Street Address

City, State, Zip

Home phone Cell phone

Email DOB

CURRENT MEDICATIONS (prescribed and over the counter)

Medication name – dose – frequency – who prescribed

ALLERGIES (medications, foods, environmental, other)

Name of agent – reaction

IMMUNIZATIONS - date(s) of most recent

Tetanus Influenza

Pneumonia COVID

PAST SURGERY / IMPLANTS – name of procedure / implant

Surgery examples – knee replacement, appendectomy, TURP

Implant examples – pacemaker, stent, DBS, artificial joints

HEALTH INSURANCE (enter here or attach copies of cards to this form)

Medicare A and B – DAI8IF8YE – Effective Date MM/DD/YYYY

Supplement Company Name – Policy # - Group #

PRIMARY CARE PROVIDER

Provider name

Practice name Phone number

FAMILY CONTACTS

Emergency Contact	Secondary Contact
Name – relationship – DPOA?	Name - relationship
Phone number	Phone number

ADVANCE DIRECTIVES [ ] Portable DNR {] POLST