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

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: ____