Emergency Medical Information

Full Name ________________________________ **Phone**_______________________________

Address __________________________________ **City/ST/Zip** ________________________________

Date of Birth ____________ **Social Security No.** _________________ **Veteran No.** ____________

Medicare No. __________________________ **Medicaid No.** ________________________________

Medicare Replacement ____________________ **Policy No.** _____________ **Phone** ____________

Medicare Supp. Insurance __________________**Policy No.** _____________ **Phone** ____________

Addl. Insurance Carrier ___________________**Policy No.** _________________**Phone**___________

Doctor's Name __________________________ **Phone**_______________________________

Hospital Preference ____

WHO TO CALL

Name _________________________Relationship ___________________ Phone ____________________

Name _________________________Relationship ___________________ Phone ____________________

Healthcare Representative/POA ________________________________ Phone ____________________

MEDICATIONS Pharmacy ________________________________ Phone __________________

Medication	Dosage	For	Prescribed By

Allergies ____

Health History/Health Problems ____

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____

____

Living Will/Location ____________________ **Do Not Resuscitate Order** ________________

Signature: ______________________________ **Date:** _______________

Place in refrigerator in a pill bottle or airtight container. Attach a sign to your refrigerator with a red emergency cross.