# Emergency Medical Information Form

**Name** _____ **Address** _____

**City** _____ **State**_____ **Zip Code**_____ **Home phone**_____

**Work phone**_____ **Cell phone** _____ **Email** _____

**Date of Birth**_____ **SSN:**_____ *(keep this information secure)* **Blood Type** _____

**Prior transfusion reaction** (describe)_____

**Please check all that apply:**

Contact lenses _____ Dentures _____ Diabetic_____ Epileptic_____ Metal in body_____

**Additional information:** _____

**Allergies to medications?**_____ Please list _____

**List all medical conditions:**_____

_____

**List Dietary Restrictions:**_____

**List all surgeries and hospitalizations:**

| Year | Surgery Performed/Reason for Hospitalization | Location |
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**Medicare Beneficiary?** Yes ____ No ____ **Medicare Part D?** Yes ____ No ____ **Medicare #** _____

**Supplementary/Insurance Company** _____ **Phone** _____

**Group #**_____ **Policy #**_____ *Attach Copy of Cards*

**Preferred Hospital:** _____

**Primary physician and/or medical treatment facility**:

Physician Name _____ Phone _____

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**Additional physicians/specialists:**

Physician Name _____ Phone _____ Specialty: _____

Physician Name _____ Phone _____ Specialty: _____

Physician Name _____ Phone _____ Specialty: _____

**Case Manager or Social Worker Information:**

Name _____ Agency _____ Agency Phone # _____

**Next of kin or person to be notified in an emergency:**

Name _____ Relationship _____ Phone _____

Email _____

Name _____ Relationship _____ Phone _____

Email _____

Name _____ Relationship _____ Phone _____

Email _____

**Legal documents:** *Attach a copy and instructions on where to access originals*

**Is there a Power of Attorney?** Yes ____ No ____

**Is there an Oklahoma Advanced Directive (Living Will)** Yes ____ No ____

**Is there a Do Not Resuscitate order?** Yes ____ No ____

**Health Care Proxy/Power of Attorney Contact Info:**

Name _____ Relationship _____ Phone _____

Email _____

**Pharmacy phone** _____

**Medication List** *Include over-the-counter, vitamins and prescription medications*

| Rx Name | Dose | When to take | Reason for taking | Prescribing M.D. |
|---|---|---|---|---|
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