# 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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