ADVANCED DIRECTIVES: Circle Yes or No

DNR: *YES OR NO*

LIVING WILL: *YES OR NO*

HEALTH CARE POWER OF ATTORNEY:
YES OR NO

IF YES, NAME: _____

Serious Medical Precautions Listed Above

PATIENT INFORMATION

Patients Last Name	First Name	Middle	Birth Date	Age	Sex

Street Address	City	State	Zip Code

Home Phone Number	Cell Phone Number

EMERGENCY CONTACT

1. Last Name	First Name	Relationship to Patient	Home Phone Number	Work Phone Number
2. Last Name	First Name	Relationship to Patient	Home Phone Number	Work Phone Number
3. Last Name	First Name	Relationship to Patient	Home Phone Number	Work Phone Number
4. Last Name	First Name	Relationship to Patient	Home Phone Number	Work Phone Number

PHYSICIAN INFORMATION

1. Physician's Name	Address	Phone Number
2. Physician's Name	Address	Phone Number
3. Physician's Name	Address	Phone Number
4. Physician's Name	Address	Phone Number

INSURANCE INFORMATION

Please list the person responsible for bill	Birth Date (if different)	Address (if different)	Home Phone No.

Occupation	Employer	Employer Address	Employer Phone No.

Are you covered by Insurance?	Please Indicate Primary Insurance

Subscriber's Name	Birth Date	Group Number	Policy Number	Relationship to Subscriber

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group Number	Policy Number

PRESCRIPTIONS AND OTHER MEDICATIONS

1. Name of Drug	Strength	Frequency Taken
2. Name of Drug	Strength	Frequency Taken
3. Name of Drug	Strength	Frequency Taken
4. Name of Drug	Strength	Frequency Taken
5. Name of Drug	Strength	Frequency Taken
6. Name of Drug	Strength	Frequency Taken
7. Name of Drug	Strength	Frequency Taken
8. Name of Drug	Strength	Frequency Taken
9. Name of Drug	Strength	Frequency Taken
10. Name of Drug	Strength	Frequency Taken
11. Name of Drug	Strength	Frequency Taken
12. Name of Drug	Strength	Frequency Taken
13. Name of Drug	Strength	Frequency Taken
14. Name of Drug	Strength	Frequency Taken
15. Name of Drug	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS

1. Name of Drug	Reaction You Had
2. Name of Drug	Reaction You Had
3. Name of Drug	Reaction You Had
4. Name of Drug	Reaction You Had

EXISTING MEDICAL CONDITIONS

SURGERIES

Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital

ADDITIONAL INFORMATION