My Emergency Medical Information

Name:_____ Date of Birth:_____

Address:_____ City:_____

Social Security Number:_____ Medicaid Policy Number:_____

Health Insurance Company:_____ Medicare Policy Number:_____

Individual/Group Policy Number:_____

My doctor/clinic is (name):_____ Phone:_____

Address:_____

Email:_____

Who to contact in and emergency:

Name:_____ Name:_____

Phone:_____ Phone:_____

Address:_____ Address:_____

Email:_____ Email:_____

Other Information:

Medications/dosages

_____

_____

_____

_____

_____

Allergies/Sensitivities:

_____

_____

_____

Special Diet:

_____

Special Needs: (Do you use equipment like a walker, wheelchair, cane, etc. Do you need special assistance due to a speech or hearing difficulty?)

_____

_____

_____

_____

_____

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