Emergency Information

Name: _____ Vision impairment Yes☐ No☐
Address: _____ Hearing Impairment Yes☐ No☐
Phone: _____ Blood Type: _____
Date of Birth: _____ Social Security #: _____
Primary Language: _____ Allergies: _____
Medical Insurance Carrier: _____
Policy #: _____
Medicaid #: _____ Medicare #: _____
Present Medical Conditions: _____
_____
Current Medications: _____
_____
Previous Hospitalizations: _____
Location of Do - Not - Resuscitate (DNR) order: _____

Emergency Numbers:

Fire: _____ Police: _____
Ambulance: _____ Poison Control: _____
Hospital: _____ Phone: _____
Doctor: _____ Phone: _____
Pharmacy: _____ Phone: _____
Primary Emergency Contact: _____
Home Number: _____
Work Number: _____
Cell Phone/Beeper Number: _____
Secondary Emergency Contact: _____
Home Number: _____
Work Number: _____
Cell Phone/Beeper Number: _____
Home Health Care Agency: _____ Phone: _____
Medicare Toll Free Number: _____
Insurance Company _____ Phone: _____
Medical Equipment Company: _____ Phone: _____
Transportation: _____ Phone: _____
Neighbor: _____ Phone: _____
Relative: _____ Phone: _____
Religious Affiliation: _____ Phone: _____
Directions to the House: _____