

# Medical Identification/Information Form

## PATIENT INFORMATION

Patients Name \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cellular(\_\_\_\_)\_\_\_\_-\_\_\_\_

## INFECTIOUS OR COMMUNICABLE DISEASES

Please List \_\_\_\_\_

## MEDICAL HISTORY QUESTIONNAIRE

Are you allergic to any Medications? (Y/N) Foods? (Y/N) If so, please list.

\_\_\_\_\_  
\_\_\_\_\_

## MEDICAL CONDITIONS

(List Each Specific Medical Condition (Angina, Emphysema, Etc. by Name)

Medical Condition \_\_\_\_\_ TX Doctor \_\_\_\_\_

Medical Condition \_\_\_\_\_ TX Doctor \_\_\_\_\_

Medical Condition \_\_\_\_\_ TX Doctor \_\_\_\_\_

Medications/Dosage \_\_\_\_\_

Medications/Dosage \_\_\_\_\_

Other Minor Medical Problems:

\_\_\_\_\_

## SPECIAL MEDICAL INFORMATION

### HOSPITAL/TREATMENT INFORMATION:

Hospitalizations/Surgeries (Condition) \_\_\_\_\_ Date \_\_\_\_\_

Hospital \_\_\_\_\_ City/State \_\_\_\_\_

Hospitalizations (Condition) \_\_\_\_\_ Date \_\_\_\_\_

Hospital \_\_\_\_\_ City/State \_\_\_\_\_

Hospitalizations (Condition) \_\_\_\_\_ Date \_\_\_\_\_

Hospital \_\_\_\_\_ City/State \_\_\_\_\_

**PHYSICIAN INFORMATION**

**PERSONAL PHYSICIAN:**

Doctors Name/Specialty \_\_\_\_\_

Doctors Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cellular(\_\_\_\_)\_\_\_\_-\_\_\_\_ Other (\_\_\_\_)\_\_\_\_-\_\_\_\_

**SPECIALISTS:**

Doctors Name/Specialty \_\_\_\_\_

Doctors Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cellular(\_\_\_\_)\_\_\_\_-\_\_\_\_ Other (\_\_\_\_)\_\_\_\_-\_\_\_\_

Do you carry a policy I.D. card? (Y/N) Policy # \_\_\_\_\_

**LEGAL DIRECTIVES/LIVING WILLS/ADVANCED DIRECTIVES**

**LIVING WILLS:**

Do you have an advanced directive or living will? (Y/N) Who can provide an original copy?

Name \_\_\_\_\_ Relationship or Profession \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Office Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cellular(\_\_\_\_)\_\_\_\_-\_\_\_\_ Other (\_\_\_\_)\_\_\_\_-\_\_\_\_

**GUARDIANSHIP OR POWER OF ATTORNEY:**

Do you have a legally executed guardian or power of attorney for your medical care? (Y/N)

Name \_\_\_\_\_ Relationship or Profession \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Office Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cellular(\_\_\_\_)\_\_\_\_-\_\_\_\_ Other (\_\_\_\_)\_\_\_\_-\_\_\_\_

**FINANCIAL AFFAIRS:**

Do you have a legal guardian or power of attorney for your financial affairs? (Y/N)

Name \_\_\_\_\_ Relationship or Profession \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Office Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cellular(\_\_\_\_)\_\_\_\_-\_\_\_\_ Other (\_\_\_\_)\_\_\_\_-\_\_\_\_

**INSURANCE INFORMATION:**

Company \_\_\_\_\_

Policy Number: \_\_\_\_\_

**RELATIVES/EMERGENCY CONTACTS**

**TO BE NOTIFIED IN CASE OF EMERGENCY :**

Name \_\_\_\_\_

Home Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cellular(\_\_\_\_)\_\_\_\_-\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cellular(\_\_\_\_)\_\_\_\_-\_\_\_\_

Name \_\_\_\_\_

Home Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cellular(\_\_\_\_)\_\_\_\_-\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cellular(\_\_\_\_)\_\_\_\_-\_\_\_\_

**AIR AND GROUND TRANSPORTATION INFORMATION:**

If you are out of your home town, Do you wish to be transferred/transported home? (Y/N)

By Ground? (Y/N) Do you wish to use anyone special? (Y/N)

Name of company \_\_\_\_\_ Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Ext. \_\_\_\_\_

Air Ambulance? (Y/N) Do you wish to use anyone special? (Y/N)

Name of company \_\_\_\_\_ Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Ext. \_\_\_\_\_

**CONSENT FOR TREATMENT, TRANSPORTATION AND RELEASE OF MEDICAL INFORMATION:**

I do hereby authorize the release of this medical record to any and all persons, who may provide me with emergency medical treatment. I hereby further consent to any lifesaving treatment as may be necessary to preserve my life and well being, provided they are not contrary to any laws or other living wills and declarations previously executed by me.

**PATIENT AUTHORIZATION:**

Print Name \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_

**WITNESSED:**

Print Name \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_