

# Emergency Information Form

(Please print clearly)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, Zip: \_\_\_\_\_

Phone: h: \_\_\_\_\_ cell: \_\_\_\_\_ e: mail: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

Lawyer: \_\_\_\_\_ Phone: \_\_\_\_\_

Closest Neighbor: \_\_\_\_\_ Phone: h: \_\_\_\_\_ cell: \_\_\_\_\_

Friend to call: \_\_\_\_\_ Phone: h: \_\_\_\_\_ cell: \_\_\_\_\_

Relative to call: \_\_\_\_\_ Phone: h: \_\_\_\_\_ cell: \_\_\_\_\_ w: \_\_\_\_\_

Relationship: \_\_\_\_\_ Where do they live? \_\_\_\_\_

Anyone else you would like us to notify in case of an Emergency:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

Phone: h: \_\_\_\_\_ cell: \_\_\_\_\_ w: \_\_\_\_\_ e-mail: \_\_\_\_\_

Known Allergies: Food \_\_\_\_\_

Medicine: \_\_\_\_\_

Other: \_\_\_\_\_

Current Health Problems, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Please use the back of this form for any other information not mentioned here that you would like us to have such as: organ donor, military discharge, property deeds, power of attorney, will, burial instructions etc.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

ALL INFORMATION IS STRICTLY CONFIDENTIAL