

Contact and Emergency Information Form

Last name: _____

Name:		Birth date:	Nickname:
Home Address:		Phone:	
Email:		Employer: Work Phone:	
Emergency Contact Name:		2nd Emergency Contact Name:	
Emergency Contact's Phone #:		2nd Emergency Contact's Phone #:	
Relationship:		Relationship:	
Primary Language:		Primary Language:	
Address:		Address:	
Signature/Consent*:			
Physicians: (Fill out all that applies)			
Primary care physician:		Emergency Phone:	
Hospital or Clinic Name:		Fax:	
Current Specialty physician:		Emergency Phone:	
Specialty:		Fax:	
Current Specialty physician:		Emergency Phone:	
Specialty:		Fax:	

Known Food Allergies:
Known Medication Allergies:
Current Medication(s):
Medical History
Choice of Hospital or Facility:
Choice of Physicians(s):
Choice of Specialists:

*Consent for release of this form to health care providers in the event of an emergency

Last name:

Diagnoses/Past Procedures/Physical Exam continued:
Protheses/Apliances/Advanced Technology Devices:

Management Data:	
Procedures to be avoided	and why:
1.	
2.	
3.	
Other Notes:	