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

Diagnoses/Past Procedures/Physical Exam continued:

Prostheses/Appliances/Advanced Technology Devices:

Last name:

Management Data:

Procedures to be avoided	and why:
1.	
2.	
3.	

Other Notes:	