Information at the Ready!

Personal

Name____________________________________ Birthdate___/___/____ SS#______-_____-______
Address

____ ____
Street City State Zip

Phone______________________________ Email____

Emergency Contact _______________________________ Relationship________________________

Phone _______________________________

Allergies (meds, food, environment, what happens)
____
____
____

Preferred language________________________

Cultural needs____

Glasses ☐Yes ☐No Hearing Aid ☐Yes ☐No

Special Dietary Needs ____

Height________________ Weight______________ Blood Type____________________

Insurance:

Primary Insurance: ___________________________ _______________ ________________________
Name ID# Group#
Phone #_________________________________

Secondary Insurance: _________________________ _______________ _______________________
Name ID# Group#
Phone #_________________________________

Information Sharing

Which family members, guardians, or other people are allowed to discuss you medical information with your doctor? If you are 18 or older, include them on your HIPAA privacy form.

Name___________________________________ Relationship_____________ Phone______________
Name___________________________________ Relationship_____________ Phone______________

Type of Care	Name of provider	Contact information
Primary Care		
Dental care		
Eye Care		
Specialist		
I.D. Care Team		
Case Worker/Social Worker		

Current Medication

Name of Medication	For what reason	Amount (dose) and how often	Doctor/Provider who prescribed

Name of Pharmacy_______________________________________ Phone______________________
Address____

Ask your primary care team for a list of your current immunizations and attach them to this document.