VITAL INFORMATION FORM

Name_____ Street Address _____

City _____State_____ Zip Code_____ Home phone_____

Work phone_____Cell phone _____ Email _____

Hair Color_____ Eye Color _____ Height_____ Weight _____

Keep this info secure: *Date of Birth*_____*SSN:*_____*Phone Pin* _____

Please check all that apply ☐ Alzheimer's Disease/Dementia ☐ Hearing Loss ☐ Blindness ☐ Pacemaker ☐ Cancer ☐ Contact Lenses ☐ Diabetes ☐Epilepsy ☐ Metal in body ☐COPD ☐Asthma ☐High Blood Pressure ☐ Heart Disease

Other Medical Conditions:_____

_____

Blood Type: _____ Prior Transfusion: Yes ☐ No ☐ Reaction (describe)_____

Allergies (Food, Medications, Environmental)_____

Dietary Restrictions:_____

Surgeries and Hospitalizations:

Year	Surgery Performed/Reason for Hospitalization	Location

Medicare Beneficiary? Yes ☐ No ☐ Medicare Part D? Yes ☐ No ☐ Medicare # _____

Primary Insurance Carrier

Insurance Carrier _____ Policy Holder's Name: _____

Policy Number _____ Group Number: _____

Phone Number _____ Pre-Certification Phone: _____

Secondary Insurance Carrier (Medicaid, Medicare, etc.)

Insurance Carrier _____ Policy Holder's Name: _____

Policy Number _____ Group Number: _____

Phone Number _____ Pre-Certification Phone: _____

Primary Physician and/or Medical Treatment Facility

Physician Name_____ Phone _____

Physician Address_____ Fax _____

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Additional Physicians/Specialists

Physician Name _____ Phone _____ Specialty: _____
Physician Name _____ Phone _____ Specialty: _____
Physician Name _____ Phone _____ Specialty: _____

Case Manager or Social Worker Information

Name _____ Agency _____ Agency Phone _____

Next of Kin or Persons to be Notified in an Emergency

Name _____ Relationship _____ Phone _____
Email _____
Name _____ Relationship _____ Phone _____
Email _____
Name _____ Relationship _____ Phone _____
Email _____

Have you prepared these Legal documents? Attach a copy and instructions on where to access originals

Document	Yes	No	Agent Name	Relationship	Phone	Email
Power of Attorney						
Living Will						
Health Care Proxy						
Last Will & Testament						

Attorney Name _____ Phone _____ Email _____
Pharmacy _____ Phone _____

Medication List - Include over the counter and prescription medications, vitamins and supplements

Rx Name	Dose	When to take	Reason for taking	Prescribing M.D. (if any)

PLEASE FILL OUT IF THIS INFORMATION IS FOR A PERSON LACKING CAPACITY

I certify that this form is for my child under 18/ward

_____ Yes, I grant permission to treat my child/ward in an emergency

_____ No, contact me prior to treating my child/ward

Responsible Party: _____ Parent _____ Guardian _____

Emergency Telephone Number: _____ Signature: _____

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