

Emergency Contact Form

Ensure that the information on this form is validated and updated periodically.

Personal Information	Date when this form was filled or updated:
Name: _____	
Work Address: _____	
Home Address: _____	City _____ State _____ Zip code _____
Home Phone: _____	Work Phone: _____ Cell Phone: _____
E-mail (Home): _____ E-mail (Work): _____	
Primary person to be notified in case of an emergency:	
Name: _____	
Relationship: _____	Relative _____ Friend _____ Other _____
Home Address: _____	
Home Phone: _____	Street Address _____ City _____ State _____ Zip code _____
E-mail Address: _____	Work Phone: _____ Cell _____
Secondary person to be notified in case of an emergency:	
Name: _____	
Relationship: _____	Relative _____ Friend _____ Other _____
Home Address: _____	
Home Phone: _____	Street Address _____ City _____ State _____ Zip code _____
E-mail Address: _____	Work Phone: _____ Cell _____

Insurance Information:	
Provider: _____	Contact person: _____
Reference No: _____	Phone: _____
List any medications you take routinely and provide details:	
Details of any medical/mobility/mental health conditions that affect you currently or in the recent past.	
List any allergies that affect you & provide details:	
Any other information that emergency personnel should be aware of:	

The information requested on this form is confidential and for emergency use only. In the event of a medical emergency, this information will be used by **Healing Waters Wellness Center LLC** and emergency personnel.

Please ensure that the form has the most updated & accurate info.

In the case of emergency, I give permission for my information to be released to emergency personnel. I also agree that any of my emergency contacts listed on this card may be notified in an emergency, as needed.

Patient Signature

Date