Patient Information for use by EMS and Staff at Receiving Medical Facility

This information is to be kept secure with the patient or with other patient records under the protection of the Health Insurance Portability and Accountability Act (HIPAA). This form is intended to provide medical personnel with needed information. It is up to the individual to determine what information will or will not be provided. Please make a copy for EMS to take.

—Please place on your refrigerator—

Demographics

Name: ____ Age: ____ Date of Birth: _____/____/_______

Address: ____ City: ______________ State: ____ Zip :________

Home Telephone: (____)_____________ Cell Phone: (____)______________

Email Address: ____ Soc. Sec. No.: ______-____-_________

Emergency Contact Name: ____

Telephone: (____)______________ Relationship: ___________________ Power of Attorney? Yes No

Insurance Information

Medicare or Medicaid: ___________________________________ Policy #: ____________________________

Private Insurance Company: ______________________________ Policy #: ____________________________

Secondary Insurance Co: _________________________________ Policy #: ____________________________

Physician Information

Physician Name: _________________________________ Physician Group: ___________________________

Physician Telephone: (____)______________ Notes:____

Medical History and Medications

Please list any Medication Allergies: ____

Please list Medical History	Please list Medications
_______________________________________	_______________________________________
_______________________________________	_______________________________________
_______________________________________	_______________________________________

Continue on back if needed