EMORY
HEALTHCARE

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

This information must be kept secure with the patient or with other medical records, in accordance with the Health Insurance Portability and Accountability Act (HIPAA). This form is intended to provide medical personnel with essential information. It is up to the individual to decide what information to include. Please make a copy for EMS to take.

Place in a Visible Spot on Refrigerator

Demographics

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

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone #: _____ Cellphone #: _____

Email Address: _____ Social Security #: _____

Emergency Contact Name: _____

Phone #: _____ Relationship: _____ Power of Attorney? Yes ___ No ___

Insurance Information

Medicare or Medicaid: _____ Policy #: _____

Private Insurance Company: _____ Policy #: _____

Secondary Insurance Company: _____ Policy #: _____

Physician Information

Physician Name: _____ Practice Name: _____

Physician Phone #: _____ Additional Info: _____

Medical History and Medications

Please list any Medication Allergies: _____

Please list Medical History	Please list Medications
_____	_____
_____	_____
_____	_____

Continue on back if needed