MEDICAL FORM

Last Name: _____ First Name: _____

Spouse Last Name: _____ Spouse First Name: _____

Birth Dates: You _____ Spouse _____

Phone Numbers (You and Spouse): _____

Local Address: _____

Other Address (if any): _____

Current Medications: _____

_____

List Allergies, if any (Medications, Foods): _____

List Any Major Medical Concerns and/or Recent Surgeries: _____

_____

PRIMARY CARE DOCTOR INFORMATION

Name of Clinic and Phone #: _____

Last Name: _____ First Name: _____

SPECIALIST DOCTOR INFORMATION (IF ANY)

Name of Clinic: _____

Last Name: _____ First Name: _____

Phone Number: _____

HOSPITAL PREFERENCE

Name of Hospital: _____

Phone Number: _____

HEALTH CARE POLICY AND PHONE NUMBERS

List Health Care Policy and Phone Numbers (e.g., Canada Hospitalization #, Primary Insurance Company and Policy #, Medicare #, Secondary Insurance Company and Policy #)

_____

_____

_____

EMERGENCY CONTACT NAME AND PHONE NUMBER

_____