Photo Pic of Self Copy & Paste

Full Name:
D.O.B
Address:
Phone:
Email:
Family, Friend, Neighbor Contacts:

Health Overview *(Include your physical activity level, any health concerns, diseases, or other pertinent information)*

DOCTORS

1. Name:
   Specialty:
   Hospital:
   Address:
   Phone Number:

YOUR Preferred Hospital:

1. Hospital:
   Address:
   Phone Number:

MYCHART/EMR Digital Medical Records, https://www.mychart.org/LoginSignup
User ID:
Password: Pin #:

SURGERIES

1. Procedure:
   Date:
   Hospital:
   Doctor:

MEDICATIONS:

1. Name:
   Milligrams:
   Frequency:
   Time of Day Taken:
   Taken For:
   Potential Side Effects:
   Refill #:

VITAMINS:

ALLERGIES:

INSURANCE:

1. Medicare
2. (A)
3. (B)
4. (Drugs)

DRIVERS LIC.:

SOCIAL SECURITY:

EMERGENCY CONTACTS:

1. Name:
   Relationship:
   Phone Number:
   Address:

HEALTHCARE PROXY – Stored in EMR (Electronic Med Rec):

DNR – Stored in EMR:

BLOOD TYPE:
ATTORNEY:

1. Name:
   Law Firm:
   Phone Number:
   Address:

FINANCIAL ADVISOR:

1. Name:
   Company::
   Phone Number:
   Address: