

# **Photo Pic of Self Copy & Paste**

Full Name:	
D.O.B	
Address:	
Phone:	
Email:	
Family, Friend, Neighbor Contacts:	
<b>Health Overview</b> (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 User ID:	, https://www.mychart.org/LoginSignup
Password:	Pin #:
SURGERIES	
1. Procedure:	
Date:	
Hospital:	
Doctor:	
MEDICATIONS:	
1. Name:	
Milligrams:	
Frequency:	
Time of Day Taken:	
Taken For:	
Potential Side Effects:	

**VITAMINS:** 

Refill #:



## **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: