



**ADVANCED DIRECTIVES:** YES or NO

**DNR:** YES OR NO

**LIVING WILL:** YES OR NO

**HEALTH CARE POWER OF ATTORNEY:** YES OR NO

**IF YES, NAME:** \_\_\_\_\_

**PHONE #:** \_\_\_\_\_

**Serious Medical Precautions Listed Above**

PATIENT INFORMATION					
Patients Last Name	First Name	Middle	Birth Date	Age	Sex
Street Address			City	State	Zip Code
Home Phone Number			Cell Phone Number		
EMERGENCY CONTACT					
1. Last Name	First Name	Relationship to Patient	Home Phone Number	Work Phone Number	
2. Last Name	First Name	Relationship to Patient	Home Phone Number	Work Phone Number	
3. Last Name	First Name	Relationship to Patient	Home Phone Number	Work Phone Number	
4. Last Name	First Name	Relationship to Patient	Home Phone Number	Work Phone Number	
PHYSICIAN INFORMATION					
1. Physician's Name	Address			Phone Number	
2. Physician's Name	Address			Phone Number	
3. Physician's Name	Address			Phone Number	
4. Physician's Name	Address			Phone Number	
INSURANCE INFORMATION					
Please list the person responsible for bill		Birth Date (if different)	Address (if different)		Home Phone No.
Occupation	Employer	Employer Address			Employer Phone No.
Are you covered by Insurance?	Please Indicate Primary Insurance				
Subscriber's Name	Birth Date	Group Number	Policy Number		Relationship to Subscriber
Name of Secondary Insurance (if applicable)		Subscriber's Name		Group Number	Policy Number



**SURGERIES**

Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital

**ADDITIONAL INFORMATION**

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