Health Information

Emergency Record Information Page 2 Date completed:____________________

Patient Name:____
Birthdate:________________________

Insurance Company Information:

Name:_________________________________ Phone:___________________________

Plan:____

Medicare: Yes No. Medicare ID #____

Plan:___________________ Medicaid: Yes No. Medicaid ID #______________________

Preferred Pharmacy:

Name:_________________________________ Phone:____________________________

Address:____

Home Health Care Agency:

Name:_______________________________ Phone:_____________________________

Contact Information: (family, friends, neighbors)

Name:__________________________________ Phone:___________________________

Name:__________________________________ Phone:____________________________

Name:__________________________________ Phone:____________________________

Name:___________________________________ Phone:___________________________

Information to share with staff in hospital or emergency room:

Patient uses/wears regularly: circle as many as apply:

Glasses Hearing Aid Dentures Adult Incontinence Wear

Brace Walker Cane Wheelchair Medical Alert bracelet/necklace

Requires monitoring because of wandering.

Other:____

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