EMERGENCY HEALTH INFORMATION

DUPONT CIRCLE VILLAGE
SHATTERING THE STEREOTYPE
ADAMS MORGAN • DUPONT CIRCLE • KALORAMA

Your Name:

Your Address:

Your Birthdate:

List any devices or implants that you have. Include lens implants for cataracts, replacements (such as hips) stimulators, pacemakers

Your Blood Type:

List Allergies or Adverse Reactions to Medications:

Your Preferred Hospital:
Name:
Address:

Your Contact Doctor:
Name:
Address:
Phone:

Your Specialist Doctor:
Name:
Address:
Phone:
Type of Specialty

Your Second Specialist Doctor:
Name:
Address:
Phone:
Type of Specialty:

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Your Medicare Information:
Number:
Part A
Part B
Contact Information:

Your Secondary Insurer:
Number :
Contact Information:

Other Insurance: (Include long-term care insurance with company and policy #)

Key Documents:

Do you have a Will? Yes_____or No_____
Where is it kept?

Please provide contact information for your Agent

Do you have a Health Care Directive? Yes_____or No_____
Where is it kept?

Please provide contact information for your Representative

Do you have a Living Will? Yes_____or No_____
Where is it kept?

Please provide contact information for your Agent

Where are those documents?

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List of Medications you are taking including amount and how often you take them

Prescriptions –date this list was made _____ / __ /

1.
2.
3.

Over the Counter Medications including Herbal Medicines

1.
2.
3.

Do you have an emergency supply of medications? Where are they kept?

Place this document in your Emergency Go Bag