DUPONT CIRCLE VILLAGE

EMERGENCY HEALTH INFORMATION

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

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:

DUPONT CIRCLE VILLAGE

EMERGENCY HEALTH INFORMATION

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

DUPONT CIRCLE VILLAGE

EMERGENCY HEALTH INFORMATION

Where are those documents?

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