Are You Prepared???

Personal Health Information

Your Contact Information

NAME: ______________________________

Date of Birth: __/__/__ **Male** __ **Female** __ **Date last updated** (aim to update form every year): ____________

Home Address: ______________________________

City: ______________ **State:** ________ **Zip:** ____________

Phone Number: ______________ **E-mail:** ______________

Parent/Guardian/Other Support Person: ______________________________

Phone Number/Other Contact Information: ______________________________

Relationship: ______________________________

Your Health Care Providers

Primary Care Physician: ______________________________

Location: ______________ **Phone Number:** ______________

Specialist Physician/Other Health Care Provider: ______________________________

Location: ______________ **Phone Number:** ______________

Specialist Physician/Other Health Care Provider: ______________________________

Location: ______________ **Phone Number:** ______________

Dentist: ______________________________

Location: ______________ **Phone Number:** ______________

Preferred Pharmacy: ______________________________

Location: ______________ **Phone Number:** ______________

Your Insurance

Employer: ______________________________

Insurance Provider (attach copies of insurance cards)**:** ______________________________

Policy Number: ______________ **Phone Number:** ______________

Dental Insurance Provider: ____

Policy Number: ______________________ **Phone Number:** ______________________

Pharmacy Insurance Provider: ____

Policy Number: ______________________ **Phone Number:** ______________________

Your Medications

Active Medications and Prescription Information (attach copies of all active prescriptions)**:**

Medication: ____

Prescription Number: ____

Instructions/Dosage: ____

Medication: ____

Prescription Number: ____

Instructions/Dosage: ____

Glasses ________ **Contact lenses** _________

Prescription: ____

Brand (contact lenses): ____

Your Health History

Medical Conditions: ____

Blood Type: ____

Allergies: ____

Diet Restrictions: ____

Immunizations (attach copies of immunization records, including dates): ____________________

____

Recent Laboratory Results (for example, blood tests and results of mammograms and pap smears): ____________

____

Recent Hospitalizations (include dates): ____

____

Recent Surgeries (include dates): ____

____

Your Pet's Health

Veterinarian:______________________________**Phone Number:** ______________________________

Immunizations (attach copies of immunization records): ______________________________

Other Pet Health Information: ____