AGIS[SM]
AssistGuide Information Services

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Emergency Contact and Medical Form

PATIENT NAME:	______	BIRTH DATE:	______
EMERGENCY CONTACT NAME:	______	HOME PHONE NUMBER:	______
EMERGENCY CONTACT ADDRESS:	______	WORK PHONE NUMBER:	______
	______	CELL PHONE NUMBER:	______

Additional Contact Name:	______	Home Phone Number:	______
Additional Contact Address:	______	Work Phone Number:	______
______		Cell Phone Number:	______
Primary Physician Name:	______	Office Phone Number:	______
Secondary Physician Name:	______	Office Phone Number:	______
Additional Physician Name:	______	Office Phone Number:	______
Health Insurance Company Name:	______	Member #:	______
Long Term Care Insurance Name:	______	Member #:	______
Medicare #:	______	Medicaid #:	______
Blood Type:	______	Uses tobacco?	☐ YES ☐ NO
Religious Beliefs:	______	Drinks alcohol?	☐ YES ☐ NO

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Emergency Contact and Medical Form

Current Medications: ______________________________
____
____

Allergies and Drug Sensitivities: ______________________________

Medical Conditions: ______________________________
____

Prior Surgeries: ______________________________
____

Other Medical Information: ______________________________

Health Care Proxy Name: ______________ Home Phone Number: ______________

Health Care Proxy Address: ______________ Work Phone Number: ______________

______________ Cell Phone Number: ______________

End of Life Preferences ______ Is a do not resuscitate order in effect? ☐ YES ☐ NO

Advance Directives: ______________________________

Document Location: ______________________________
____

Police Phone Number: ______________ Fire Station Phone Number: ______________

Hospital Phone Number: ______________ Pharmacy Phone Number: ______________

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