FRONT OF CARD

INSURANCE INFORMATION

COMPANIES: POLICY#: PHONE:

MEDICARE #

PHYSICIANS: PHONE: ( )

DR.

DR.

DR.

PLEASE CONTACT THE PERSON(S) OR ORGANIZATION(S) LISTED BELOW FOR INFORMATION ON LIVING WILL OR DONOR INFORMATION:

NAME:

PHONE: ( )

NAME:

PHONE: ( )

Pharmacist

Pharmacy Location

Phone: Fax:

Blood Type: Height: Weight:

Date of your last tetnus shot? / /

Date of your last pneumonia shot? / /

Date of your last flu shot? / /

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NAME

ADDRESS

CITY STATE ZIP

PHONE ( )

BIRTHDATE MALE ☐ FEMALE ☐

RELIGION

DATE THIS MEDICAL FORM WAS COMPLETED / /

EMERGENCY MEDICAL RECORD

Nurses & Company

Home Health, Hospice, Private Services

636-926-3722 • 314-685-3722

ATTENTION: POLICE/MEDICAL

IN CASE OF EMERGENCY PLEASE NOTIFY

NAME

ADDRESS

CITY STATE ZIP

PHONE ( )

LIVING WILL? YES☐ NO☐ DONOR? YES☐ NO☐

DURABLE POWER OF ATTORNEY FOR HEALTH CARE? YES☐ NO☐

BACK OF CARD

I AM TAKING THE FOLLOWING MEDICATIONS:

Include over the counter and herbal products

DRUG NAME?	STRENGTH?	DOSAGE?	HOW OFTEN / WHEN?	WHAT IS IT FOR?

HAVE THIS VERIFIED BY YOUR PHYSICIAN OR PHARMACIST EACH VISIT. **KEEP THIS CARD WITH YOU AT ALL TIMES.**

MEDICAL CONDITION? (HEART DIABETES ETC).	ALLERGIES? (PENICILLIN, SULFA ETC).	WHAT HAPPENS WHEN YOU TAKE IT? (BRIEFLY EXPLAIN)