

**Medical Information Sheet**

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

**Health Insurance**

Insurance Provider \_\_\_\_\_

Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_

Name of Insured (subscriber) \_\_\_\_\_

**Medical Information**

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you allergic to any foods or environmental allergens?  NO  YES

Please list: \_\_\_\_\_

Are you allergic to any medications?  NO  YES

Please list: \_\_\_\_\_

List Medical Conditions (for example: heart disease, diabetes, seizures, etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list the medications you are currently taking: (please use reverse side if more space is needed)

Name of Medication	Dosage	How often?