Medi-Card

To assist DeKalb Medical and other healthcare providers in delivering the best care possible, please print and fill out this form with all of your pertinent medical information and keep it with you at all times. Please be sure to share this information during your regularly scheduled office visits, and make sure someone else knows where it is kept in case of an emergency.

Name:	
Date of Birth:	
Home Phone:	
Cell Phone:	

Medication	**Dosage (mg)**	**Times per Day?**

Vaccines (Date) [Ex: 01/01/2010)	
Flu:	
Pneumonia:	
Tetanus:	

Allergies	Reaction

Surgical History

Procedure	Date

Name:	

Medical conditions for which I am being treated:

Do you have a(n):

Living Will	**Yes/No**
Advanced Directive for Health Care	**Yes/No**

Healthcare Agent Name:	
Phone:	

Other Emergency Phone Numbers:

Name:	
Date of Birth:	
Home Phone:	
Cell Phone:	
Name:	
Date of Birth:	
Home Phone:	
Cell Phone:	

Name:	