Medi-Card

To assist us 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		
Surgical History Procedure	Date	
	Date	

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:		