Form 750

SMILES LIKE YOURS Emergency Medical Information Form

1. Individual:

_____

2) Person to be notified in an emergency:

_____

Relation:

_____

Emergency Contact's Address:

_____

City: State:_____Zip Code_____

Emergency Contact's Phone Number: 1. _____

2. _____

3) Physician Information

Client's Physician:

_____

Physician's Phone:

_____

Physician's Address:

_____

City:_____State:_____Zip Code:_____

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4) Insurance Information:

Medical Insurance Company:_____Policy Number:_____

Medicaid/Medicare/CHAMPUS number:

_____

Current Medications (prescribed and over the counter)

Med Name	Dosage	Route	Time	Prescribing Doctor	Reason

5) Allergies (medications and food)

6) Any History of Substance Abuse?

none

7) Does the individual have significant medical problems or conditions? (please explain and bespecific)

8) Does the client have significant ambulatory or sensory problems? (please explain and be specific)

9) Does the client have significant communication problems? (please explain and be specific)

10) Advance Directive if one exists?