

Patient Information for use by EMS and Staff at Receiving Medical Facility

This information is to be kept secure with the patient or with other patient records under the protection of the Health Insurance Portability and Accountability Act (HIPAA)

This form is intended to provide medical personnel with needed information. It is up to the individual to determine what information will or will not be provided. Please make a copy for EMS to take.

—Please place on your refrigerator—

Demographics

Name: _____ Age: ____ Date of Birth: ____/____/____

Address: _____ City: _____ State: ____ Zip: _____

Home Telephone: (____) _____ Cell Phone: (____) _____

Email Address: _____ Soc. Sec. No.: _____ - _____ - _____

Emergency Contact Name: _____

Telephone: (____) _____ Relationship: _____ Power of Attorney? Yes No

Insurance Information

Medicare or Medicaid: _____

Private Insurance Company: _____ Policy #: _____

Secondary Insurance Co: _____ Policy #: _____

Please provide insurance information even if you are a member of the EMS Subscription Fund. Insurance and Medicare will still be billed. We will use your information above to identify you as an EMS Fund member.

Physician Information

Physician Name: _____ Physician Group: _____

Physician Telephone: (____) _____ Notes: _____

Medical History and Medications

Please list any Medication Allergies: _____

Please list Medical History

Please list Medications

Continue on back if needed