Date: _____

Personal Information

THIS INFORMATION BELONGS TO

Name: _____

Sex: M F Race: _____ Height: _____

Eyes:_____ Hair:_____ Weight _____

BLOOD TYPE ☐ A ☐ B ☐ AB ☐ O+ ☐ O-

I HAVE: ☐ pacemaker ☐ contacts ☐ metal pins or plates

☐ **YES**, I have a reaction to IV contrast dye.

Religion: _____

ID – scar, tattoo etc: _____

SSN:_____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

☐ House ☐ Apartment ☐ Assisted Living ☐ Nursing Home

Phone

Cell: _____ Home: _____

Fax: _____

Email: _____

HEALTH CARE PROVIDER INFO (Also see **Health Care Provider section)**

Doctor: _____ Phone:_____

Preferred Hospital: _____

Pharmacy: _____ Phone: _____

Specialist: _____

Phone: _____

Specialist: _____

Phone: _____

EMERGENCY CONTACT PERSON #1 (Spouse or other)

Name: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell: _____ Other: _____

Email: _____

They have a copy of my advance directives

Yes No

EMERGENCY CONTAT PERSON #2 (Spouse or other)

Name: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell: _____ Other: _____

Email: _____

They have a copy of my advance directives

Yes No

DECISIONS ABOUT MEDICAL TREATEMENT

☐ **YES**, I have advanced directives ☐ Living will ☐ Health care power of attorney). Please see copies of official
☐ Documents in this section. The original documents can be found at _____
☐ **DO NOT** Resuscitate (DNR). Please see forms on the following pages.
☐ **NO, I DO NOT** wish to be an organ donor.
☐ **YES**, I am or wish to be an organ and tissue donor (see copy of donor registration forms in this section).