

# MEDICAL INFORMATION FORM

**PLEASE PRINT CLEARLY**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Cell # \_\_\_\_\_

Member of what Church? \_\_\_\_\_

Other Insurance: Company \_\_\_\_\_

Group # or name \_\_\_\_\_

Policy # \_\_\_\_\_

Someone to notify case of emergency: Name \_\_\_\_\_

Relationship \_\_\_\_\_

Day Time Phone \_\_\_\_\_ Night Telephone \_\_\_\_\_

Medical History \_\_\_\_\_

\_\_\_\_\_

Allergies: \_\_\_\_\_

Blood Type: \_\_\_\_\_

Medications now taking: \_\_\_\_\_

Family Doctor name: \_\_\_\_\_ Phone \_\_\_\_\_

I hereby authorize release of this information to any physician, hospital, or clinic as needed for my medical care and/or in case of accident or emergency.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_