PEACE OF MIND
FAMILY NETWORK

In My Own Words - Medical Information

Form completed by _____
Date _____
My Birthdate is _____ My Gender is ____

As of the above date, this list reflects my current medical status.

My Primary Physician is:

Name _____
Practice or Hospital Affiliation _____
City _____ State _____
Phone Number _____

I am also under care for _____. condition
The Specialist who treats me is:
Name _____
Practice or Hospital Affiliation _____
City _____ State _____
Phone Number _____

I am also under care for _____. condition
The Specialist who treats me is:
Name _____
Practice or Hospital Affiliation _____
City _____ State _____
Phone Number _____

I am also under care for _____. condition
The Specialist who treats me is:
Name _____
Practice or Hospital Affiliation _____

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City _____ State _____
Phone Number _____

I am also under care for _____. condition
The Specialist who treats me is:
Name _____
Practice or Hospital Affiliation _____
City _____ State _____
Phone Number _____

My known allergies are _____

My current medical condition is/are
_____

I am an organ donor _____ Y/N

My Blood Type is _____

I have the following implants:
_____
My past surgical history is:
_____
_____
_____

My Insurance/Medical Benefits are provided by:

Insurer: _____
Type of Coverage _____
My Group number is _____ My ID Number is _____
The pre procedure approval phone number is _____
I have also provided an image of my benefits card _____ Y/N

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Secondary Medical Benefits are provided by:

Insurer: _____
Type of Coverage _____
My Group number is _____ My ID Number is _____
The pre procedure approval phone number is _____
I have also provided an image of my benefits card _____ Y/N

I have an Advanced Health Care Directive _____ Y/N.

I have a signed a HIPAA authorization that directs the following individuals who may be advised of my medical condition.

Person _____ Relationship _____
Phone _____

Person _____ Relationship _____
Phone _____

Person _____ Relationship _____
Phone _____

I am currently taking the following Medications:

Medication Name _____
Dosage Amount _____ Which I take _____ times each day.

Medication Name _____
Dosage Amount _____ Which I take _____ times each day.

Medication Name _____

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Dosage Amount _____ Which I take _____ times each day.

Medication Name _____
Dosage Amount _____ Which I take _____ times each day.

Medication Name _____
Dosage Amount _____ Which I take _____ times each day.

Comments: