Emergency Medical Form

Patient information		
First name:		**Last name:**
Preferred name:		**Patient identifier (if known):**
Gender:		**Preferred pronouns:**
Date of birth:		**Marital status:**
Address:		
City:	**State:**	**Zip code:**
Email:		**Preferred phone number:**
Emergency contact		
Full name:	**Relationship:**	**Contact number:**
Full name:	**Relationship:**	**Contact number:**
Medical information		
Primary care physician:		**Contact number:**
Address:		
Please list any medical conditions:		
Please list any medication:		
Please list any allergies:		
Additional information:		
Emergency medical consent		
I, _____ ,consent _____ authorizing medical care for _____ in the event of an emergency.		
Parent or guardian name (if applicable):		**Relationship to patient (if applicable):**
Signature of patient, parent, or guardian:		**Date:**