Face Sheet Medical

Patient information	
Patient name:	

Date:	**Date of birth:**
Age:	**Sex:**
Marital status:	**Ethnic origin:**

Address:
Address:

Email:	**Phone number:**
Emergency contact:	**Relationship:**

Emergency contact email / phone number:

Secondary contacts:	**Secondary contact email / phone number:**

Legal representatives:

Primary insurance	
Name of insurance:	
Insurance phone number:	
Policyholder name (as it appears on the card):	
Policy number:	

Date of birth:	**Social security number:**
Group name:	**Group number:**

Relationship to policyholder (if applicable):

Secondary insurance	
Name of insurance:	
Insurance phone number:	
Policyholder name (as it appears on the card):	
Policy number:	
Date of birth:	**Social security number:**
Group name:	**Group number:**
Relationship to policyholder (if applicable):	

Medical history	
Family health history:	**Current medical conditions (including any allergies):**
Past medical conditions:	**Past surgeries and hospitalizations:**
Past and current medications:	**Vaccinations:**

Patient preferences

Treatment:	Communication:

Care:	Privacy:

Dietary:	Other:

Additional information

Clinician name:	Date:

Clinician contact information: