CareQuest® Caring, Assistance, Solutions, Providers and Services Online

National Work & Family Life Programs

Health Provider and Emergency Information Form

Keep a copy of this form next to your phone; a copy next to your bed; and a copy in your wallet.

Your Information

Your Name: _____

Birthdate: _____ / _____ / _____
month day year

Weight: _____ Height: _____

Address: _____

_____

Day Phone: ( ) _____

Eve. Phone: ( ) _____

Medical Information

Allergies: _____

Blood Type Rh: _____ Group: _____

Medical Conditions: _____

_____

Current Medications: _____

_____

_____

Notify in Case of Emergency

Name: _____

Address: _____

Home/Day Phone: _____

Work/Evening Phone: _____

Additional Contact

Name: _____

Address: _____

Home Phone: _____

Work Phone: _____

Medical Power of Attorney

Name: _____

Address: _____

Home Phone: _____

Work Phone: _____

Health Insurance/HMO

Group # _____ Subscriber # _____

Policy # _____

Company _____

Please see next page for emergency and non-emergency contact information.

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Ambulance/Fire

Phone: _____

Police

Emergency Phone: _____

Non-Emergency Phone: _____

Poison Control

1-800-222-1222

Hospital

Name: _____

Address: _____

Phone: _____

Primary Doctor

Name: _____

Address: _____

Phone: ( ) _____

Pharmacy

Name: _____

Address: _____

Phone: ( ) _____

Personal Care Attendant

Name: _____

Address: _____

Phone: ( ) _____

Nurse

Name: _____

Address: _____

Phone: ( ) _____

Eye Doctor

Name: _____

Address: _____

Phone: ( ) _____

Physical Therapist

Name: _____

Address: _____

Phone: ( ) _____

Lawyer

Name: _____

Address: _____

Phone: ( ) _____

Geriatric Care Manager/Social Worker

Name: _____

Address: _____

Phone: ( ) _____

Chiropractor

Name: _____

Address: _____

Phone: ( ) _____

Other Provider

Name: _____

Address: _____

Phone: ( ) _____