ALTMAN
& ASSOCIATES

Exclusively Estate Law

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Planning for Emergencies: Complete this form and keep it somewhere that is easy for you and your loved ones to access. Bring it with you during any hospital visit.

TAKE THIS COMPLETED FORM WITH YOU!

Name: _____

Address: _____

_____

Date of Birth: _____ Gender: M F

Primary Language: _____ Religion: _____

Primary Doctor's Name: _____

Doctor's Phone: _____

Doctor's Address: _____

CHECK ALL MEDICAL CONDITIONS THAT EXIST

- ☐ No known medical condition
- ☐ Abnormal EKG
- ☐ Adrenal insufficiency
- ☐ Alcohol Addiction
- ☐ Allergies
- ☐ Alzheimer's
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disorder
- ☐ Blind
- ☐ Cancer
- ☐ Cardiac Dysrhythmia
- ☐ Cataract
- ☐ Congestive Heart Failure
- ☐ Chronic Bronchitis
- ☐ COPD
- ☐ Corona Bypass Graft
- ☐ Deafness
- ☐ Dementia
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hemodialysis
- ☐ Hypertension
- ☐ Internal Defibrillator
- ☐ Irregular Heart Rhythm
- ☐ Kidney Disease
- ☐ Laryngectomy
- ☐ Leukemia
- ☐ Lung Disease/Emphysema
- ☐ Lupus
- ☐ Lymphomas
- ☐ Macular Degeneration
- ☐ Malignant Hypothermia
- ☐ Mental Illness
- ☐ Multiple Sclerosis
- ☐ Myasthenia Gravis
- ☐ Osteoarthritis / Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Previous Heart Attack
  Date _____
- ☐ Pulmonary Hypertension
- ☐ Rheumatoid arthritis

Other: _____

_____

_____

MEDICATIONS

Medical Problem	Medication	Dosage	Frequency

Date of last tetanus shot _____

Date of last flu shot _____

Date of last pneumonia shot _____

Shingles shot ☐ Yes ☐ No

EMERGENCY CONTACTS

#1 Name: _____

Address: _____

Relationship: _____ Phone: _____ Cell: _____

_____

#2 Name: _____

Address: _____

Relationship: _____ Phone: _____ Cell: _____

HEALTH INSURANCE INFORMATION

Medicare Number: _____

Primary Insurance: _____

Policy No. / Member ID / Group No.: _____

Other Insurance: _____

Policy No. / Member ID / Group No.: _____

Estate Planning Lawyer Contact Information:

_____

Who is appointed to make health care decisions for you:

Name & Contact Info: _____

_____

_____

Take this form with you when you go to the hospital! Because of privacy laws, HIPAA (Health Insurance Portability and Accountability Act) authorizations will not permit doctors to discuss your medical situation with others. Be sure you have: 1) **Durable Power of Attorney,** 2) **Designation of Health Care Surrogate** and a 3) **Living Will**.