

Emergency Contact #2:

Name _____

Relationship _____

Is my Health Care Proxy Agent

Day phone _____

Evening phone _____

Cell phone _____

E-mail _____

Address _____

City _____ State _____ Zip _____

Other info _____

Emergency Contact #3:

Name _____

Relationship _____

Is my Health Care Proxy Agent

Day phone _____

Evening phone _____

Cell phone _____

E-mail _____

Address _____

City _____ State _____ Zip _____

Other info _____

Others in household _____

Pets _____

open/over ⇨

PLEASE PRINT

Emergency Information for

(name)

(address)

New York, NY 10025

Day phone _____

Evening phone _____

Cell phone _____

E-mail _____

Primary language _____

Emergency Contact #1:

Name _____

Relationship _____

Is my Health Care Proxy Agent

Day phone _____

Evening phone _____ - _____

Cell phone _____

E-mail _____

Address _____

City _____ State _____ Zip _____

Other info _____

**First Responders: See reverse side for more
Emergency Health Information.**

*This form was prepared for your convenience by
Bloomingdale Aging in Place / bloominplace.org
(212) 842-8831 – info@bloominplace.org*

EMERGENCY HEALTH INFORMATION

Updated on _____

PLEASE PRINT

NAME: _____

(see reverse for address/phone/other contact info)

Age: _____ Birthdate: _____ Blood type: _____

Allergies _____

Language/Assistive Devices/Equipment/Other: _____

Current medical conditions, inc. any recent procedures _____

Medical Insurance: Medicare # _____

Other medical Insurance type & ID number: _____

Medicaid # _____

Emergency contacts: see reverse side. I have a: Health Care Proxy
 Living Will Non-hospital DNR order

Physician Name:	Specialty:	Phone:
DR. _____	_____	_____
DR. _____	_____	_____
DR. _____	_____	_____
DR. _____	_____	_____
DR. _____	_____	_____
Preferred Hospital: _____		
Pharmacy: _____		Phone _____
<input type="checkbox"/> see Medication List attached		