Verus Healthcare

Patient Emergency Information Form

Date:

Personal Information

Patient ID	
First name	
Middle name	
Last name	
Gender	
Married or Single?	
Language Preference	
Home Street Address	
City, State Zip Code	
COUNTY	
Home phone	
Cellular phone	
Email address	
Date of Birth (MM/DD/YYYY)	
Government ID or SSN	

Emergency Information

Emergency contact's name (Local)	
Relationship	
Street Address	
City, State, Zip Code	
Home Phone	
Cellular Phone	
Do you live in a Flood Prone Area?	YES or NO

Emergency Information

Emergency contact's name (NON-Local)	
Relationship	
Street Address	
City, State, Zip Code	
Home Phone	
Cellular Phone	

Medical Information

Primary Care Doctor's name	
Address	
Phone number	
Blood type	
Allergies	
List all your Medical conditions	
Current all your current medications (indicate if any medications require refrigeration)	
List all Life Sustaining and/or Electrically Dependent Medical Equipment, you are currently using, and the related supplies they may require: (examples: Oxygen concentrators or portable Oxygen tanks (liquid/gas), CPAP machines, Nebulizers, Wheelchairs, walkers, Hearing impaired or Sight impaired assistance devices, Other equipment.)	
Medical Equipment Provider Info	Name: Phone:

Emergency Plan / Evacuation Information

Do you currently have an Emergency & Evacuation Plan in place at your residence?	YES	or	NO
Do you have Emergency Power Backup (such as a generator) should the power go out during an emergency?	YES	or	NO
Are you interested in registering with your County Special Needs Shelter should you need to be evacuated during an emergency?	YES	or	NO
Would you like assistance registering with the Special Needs Shelter in your County?	YES	or	NO

PATIENT SIGNATURE:
____ date: ___________