Patient Better®
The Emergency Form

Last Updated: _____/_____/_____   **Form filled out by: _____**

Name: (First Last)   D.O.B   Blood Type   Gender

_____ _____ ___/___/___   _____   _____

Religion   Language Spoken   Ethnicity   Phone

_____ _____ _____ _____

Pharmacies:
_____
_____
_____

Emergency Contact Person (First Last) Phone #, Relationship, Language Spoke, Email Address
1._____   _____ _____ _____
2. _____   _____ _____ _____

Current Treating Primary Care Physician (First Last), Facility Name, Location, Phone and Nurse's Name
Dr. _____   _____
_____

Medical Conditions (Infections, Allergies, Chronic Condition, State of Condition. & Date Acquired):
Allergies
_____
_____
_____

Medications and/or Suppliments:
_____   _____
_____   _____
_____   _____
_____   _____
_____   _____

Date of last Tetanus shot and Clinic that Administered and ID:

_____

Medical Office Use:

Reason for Emergency Room Visit:

_____

_____

_____

_____

Treating Physician, Name of Facility, Location, Phone Number:

_____

_____

_____

Diagnosis and Treatment:

_____

_____

_____

Service:

_____

_____

_____

Medication:

_____

_____

_____

Follow Up Directions:

_____

_____

_____

_____