MEDSTAR
EMERGENCY MEDICAL SERVICES

Personal Information

Name: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____

Gender: ☐ Male ☐ Female Social Security Number: _____

Primary Insurance Co. _____

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

Secondary Insurance Co. _____

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

Do you have a Do Not Resuscitate Order? ☐ No ☐ Yes (If Yes, please attach)

Notify in Case of Emergency

Name: _____

Relationship: _____ Phone: _____

Name: _____

Relationship: _____ Phone: _____

Pet Name/Type: _____

Pet Sitter: _____ Phone: _____

Medical Information

Primary Physician: _____ Phone: _____

Primary Physician: _____ Phone: _____

Preferred Hospital: _____

Height: _____ Weight: _____ Normal Blood Pressure: _____

Drug Allergies *(specify):* _____

Food Allergies *(specify):* _____

What medical issues/physical disabilities do you have? *(heart problems, diabetes, high blood pressure, etc.)*
(be as specific as possible)

_____

_____

Do you wear: ☐ Contacts ☐ Hearing Aids
☐ Dentures ☐ Glasses ☐ Use Oxygen

817-923-3700 (phone) / 817-632-0537 (fax) 551 E. Berry St. Fort Worth, TX 76110 info@medstar911.org

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Past Surgeries *(type and date):*

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Current Medications (include prescription, over-the-counter drugs, vitamins and herbal supplements)

Where do you keep your medications? _____

Medication: _____ Dosage/Time: _____

Purpose: _____

Medication: _____ Dosage/Time: _____

Purpose: _____

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Purpose: _____

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Purpose: _____

Medication: _____ Dosage/Time: _____

Purpose: _____

Medication: _____ Dosage/Time: _____

Purpose: _____

Additional Information: _____