



Family Medical Emergency Protocol



PLANNED FINANCIAL
services

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NAME _____ DOB _____ BLOOD TYPE _____ LAST UPDATED _____

ADDRESS _____

SPOUSE NAME _____

IN THE EVENT OF AN EMERGENCY **DIAL 911**

Police Department non-emergency phone # _____

Fire Department non-emergency phone # _____

Poison Control non-emergency phone # _____

HOSPITAL/EMERGENCY ROOM

Preferred hospital name/address/phone number _____

Emergency Room name/address/phone number _____

Urgent Care Facility name/address/phone number _____

MEDICAL INSURANCE INFORMATION

Member: Self Spouse

Health Insurance Plan Name _____ Company Sponsor _____

Health Plan # _____ Group ID # _____ Payer ID # _____

Member ID# _____ Medicare ID# _____

Claims Address _____

Phone Number _____ Website _____

PERSONAL INFORMATION

Allergies

Pre-existing Conditions / Prior Surgeries and Dates

Vaccines and Immunizations, including date of last Tetanus shot



Your Name _____

PHYSICIAN/HEALTHCARE PROVIDERS

PRIMARY CARE PHYSICIAN

Practice name and address: _____

Doctor Name _____ Phone _____ After-Hours Phone _____

SPECIALIST 1

Practice name and address: _____

Doctor Name _____ Phone _____ After-Hours Phone _____

SPECIALIST 2

Practice name and address: _____

Doctor Name _____ Phone _____ After-Hours Phone _____

SPECIALIST 3

Practice name and address: _____

Doctor Name _____ Phone _____ After-Hours Phone _____

SPECIALIST 4

Practice name and address: _____

Doctor Name _____ Phone _____ After-Hours Phone _____

DENTIST

Practice name and address: _____

Doctor Name _____ Phone _____ After-Hours Phone _____

OPHTHALMOLOGIST

Practice name and address: _____

Doctor Name _____ Phone _____ After-Hours Phone _____

PEDIATRICIAN

Practice name and address: _____

Doctor Name _____ Phone _____ After-Hours Phone _____

VETERINARIAN

Practice name and address: _____

Doctor Name _____ Phone _____ After-Hours Phone _____



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EMERGENCY CONTACTS

Your Name _____

Contact the following family members/friends/business associates in the event of an emergency or incapacitation:

PERSONAL

Name (1) _____ Relationship _____

Mobile Phone _____ Home Phone _____ Work/Alternate Phone _____

Name (2) _____ Relationship _____

Mobile Phone _____ Home Phone _____ Work/Alternate Phone _____

FINANCIAL ADVISOR

Contact _____ Phone _____ After-Hours Phone _____

Firm/Address _____

ATTORNEY

Contact _____ Phone _____ After-Hours Phone _____

Firm/Address _____

TAX ADVISOR/CPA

Contact _____ Phone _____ After-Hours Phone _____

Firm/Address _____

OTHER ADVISOR

Contact _____ Phone _____ After-Hours Phone _____

Firm/Address _____

BANK/FINANCIAL INSTITUTION (1)

Contact _____ Phone _____ After-Hours Phone _____

Institution/Address _____

BANK/FINANCIAL INSTITUTION (2)

Contact _____ Phone _____ After-Hours Phone _____

Institution/Address _____

BANK/FINANCIAL INSTITUTION (3)

Contact _____ Phone _____ After-Hours Phone _____

Institution/Address _____

