

PATIENT INFORMATION

Effective from: \_\_\_\_\_

Effective through: \_\_\_\_\_

Patient name: \_\_\_\_\_

Patient address: \_\_\_\_\_

Patient city: \_\_\_\_\_

Patient state: \_\_\_\_\_

Patient zip: \_\_\_\_\_

Patient home phone: \_\_\_\_\_

Patient cell phone: \_\_\_\_\_

Patient e-mail address: \_\_\_\_\_

Patient Social Security no. (optional): \_\_\_\_\_

Patient sex: \_\_\_\_\_

Patient primary language: \_\_\_\_\_

Patient height: \_\_\_\_\_

Patient weight: \_\_\_\_\_

Eye color: \_\_\_\_\_

Patient blood type: \_\_\_\_\_

Patient marital status: \_\_\_\_\_

Patient's number of children: \_\_\_\_\_

File: [Patient]/current/patient\_info/ or when saving to history [Patient]/history/patient\_info/[date]

PATIENT INFORMATION ALLERGIES

Effective from: \_\_\_\_\_

Effective through: \_\_\_\_\_

Patient name: \_\_\_\_\_

Allergen: \_\_\_\_\_

Reaction: \_\_\_\_\_

Date of onset: \_\_\_\_\_

Date of last episode: \_\_\_\_\_

Treatment method: \_\_\_\_\_

Doctor treating allergy: \_\_\_\_\_

File: [Patient]/current/patient\_info/allergies/[Allergen]

EXHIBIT 6-3 MEDICAL HISTORY CHECKLIST

Abdominal pain (colic in infants)	Fainting	Open wounds	Warts
Acne	Fibromyalgia	Osteoarthritis	CANCER
ADHD/ADD	Gastritis	Osteoporosis	Breast cancer
AIDS	Gastro esophageal reflux disease (GERD)	Pain or pressure in chest	Colon/rectal cancer
Alcoholism	Genital warts	Palpitations	Leukemia
Alzheimer's disease	Glaucoma	Paralysis	Lung cancer
Anemia	Gonorrhea	Parkinson's disease	Non-Hodgkin's lymphoma
Arthritis	Gout	Pelvic inflammatory disease	Ovarian cancer
Asthma	Hay Fever/sinus problems	Peptic ulcer disease	Prostate cancer
Athlete's foot	Head lice	Periods of unconsciousness	Skin cancer
Autism	Hemodialysis	Pertussis/whooping cough	Urinary/bladder cancer
Bladder/kidney infections	Hemorrhoids	Phlebitis	Uterine cancer
Blocked tear duct	Hepatitis	Pneumonia	Other cancer
Blood clotting disorder	Hernia	Polio	FEMALES
Breast lumps	Herpes	Pulmonary embolism	Abnormal PAP
Bronchitis	HIV positive	Rash	Bleeding problems
Bursitis	Hives	Rectal bleeding	Breast mass or cyst
Canker sores	Hypoglycemia	Rheumatic fever	Contraceptions
Carpal tunnel syndrome	Hypothyroidism	Rheumatism	Cyst or abscess of vulva
Cataracts	Impetigo	Ringworm	Discomfort with sex
Cellulites	Incontinence	Rubella	Endometriosis
Chickenpox	Infertility	Scabies	Fibroids
Chlamydia	Irritable bowel syndrome (IBS)	Scarlet fever	Irregular periods
Chronic constipation	Jaundice	Scoliosis	Menopause
Chronic obstructive pulmonary disease	Kidney disease	Seizures/seizure disorder	Miscarriage
Chronic pain	Kidney failure	Sexual dysfunction	Nipple discharge
Colitis Crohn's disease	Limb pain	Shingles	Ovarian cysts
Colon polyps	Liver problems	Shortness of breath (dyspnea)	Postmenopausal bleeding
Conjunctivitis (pink eye)	Low blood pressure	Sickle cell	Postpartum depression
Corneal abrasions	Lupus	Sinus infection	Pregnancy
Depression	Lyme disease	Skin lesion	Toxemia
Diabetes Type I	Measles	Smoking	Tubal pregnancy
Diabetes Type II	Meningitis	Stomach or intestinal problems	CHILDREN
Diarrhea	Mental health/psychiatric disorder	Strep throat	Birthmarks
Dizziness	Migraine headache	Stroke	Cradle cramp
Drug dependency	Mononucleosis	Swimmer's ear	Croup
Ear infections/hearing impairment	Multiple Sclerosis	Syphilis	Hand, foot, and mouth disease
Eczema and psoriasis	Mumps	Thyroid problems	Mental retardation
Emphysema	Muscle disorder	Tonsillitis	Pinworms
Epilepsy	Neck pain	Tuberculosis	Roseola (baby measles)
Eye problem	Nose bleeds	Tumor	MALES
	Numbness	Upper respiratory infection	Prostate problems
		Urinary tract infections	
		Varicose veins	

EXHIBIT 6-4 SURGERIES AND PROCEDURES

Abdominal surgery	CT scan	Mammogram
Abortion	Cystoscopy	Mastectomy
Angiogram	Dialysis	MRI
Angioplasty	Dilation & curettage (D&C)	Myelogram
Ankle/leg fracture repair	Electrocardiogram (EKG)	Oophorectomy
Appendectomy	Episiotomy	Pacemaker
Arterial line placement	Fusions (e.g., lumbar)	PET scan
Artificial insemination	Gall bladder removal (cholecystectomy)	Prostatectomy
Aspiration of breast cyst	Gastroscopy	Pulmonary artery catheter placement
Back surgery	Glaucoma surgery	Radial keratotomy (RK)
Bladder repair	Heart bypass surgery	Radiation treatment
Blood transfusion	Heart valve replacement	Radiograph
Bone scan	Hemorrhoid surgery	Shoulder surgery
Cardiac catheterization	Hernia repair	Sigmoidoscopy
Carpal tunnel surgery	Hip replacement	Spinal tap/lumbar puncture
Cataract surgery	Hysterectomy	Splenectomy
Cesarean section	In-vitro fertilization (IVF)	Stress test
Chemotherapy	Joint aspiration	Thyroidectomy
Chest tube placement	Knee replacement	Tonsillectomy
Circumcision	Knee surgery	Tracheostomy
Colonoscopy	Laminectomy	Transurethral prostate surgery
Colorectal resection	Laparoscopy	Tubal ligation (female sterilization)
Colposcopy	Laparotomy	Ultrasound
Coronary artery bypass grafting (CABG)	LASIK	Vasectomy (male sterilization)
Cosmetic surgery	LEEP	
Craniotomy	Lumpectomy	

PATIENT INFORMATION MEDICAL HISTORY Effective from: \_\_\_\_\_

Effective through: \_\_\_\_\_

Patient name: \_\_\_\_\_

Condition: \_\_\_\_\_

Is this condition active or resolved? \_\_\_\_\_

Doctor treating this condition: \_\_\_\_\_

Date of onset: \_\_\_\_\_

Date of diagnosis: \_\_\_\_\_

Date of treatment: \_\_\_\_\_

Method of treatment: \_\_\_\_\_

Medication: \_\_\_\_\_

Diet: \_\_\_\_\_

Exercise: \_\_\_\_\_

Hospitalization: \_\_\_\_\_

Surgery: \_\_\_\_\_

Date of surgery: \_\_\_\_\_

Affected body area: \_\_\_\_\_

Outcome: \_\_\_\_\_

Doctor who performed the surgery or procedure: \_\_\_\_\_

Therapy: \_\_\_\_\_

Other: \_\_\_\_\_

Date of resolution: \_\_\_\_\_

File: [Patient]/current/patient\_info/med\_history/[date of condition]

FAMILY MEMBER INFORMATION  
MEDICAL HISTORY

Effective from: \_\_\_\_\_

Effective through: \_\_\_\_\_

Family member name: \_\_\_\_\_

Family member relation to patient: \_\_\_\_\_

Patient name: \_\_\_\_\_

Is this family member living? \_\_\_\_\_

If this family member is deceased,  
cause of death? \_\_\_\_\_

Condition: \_\_\_\_\_

Is this condition active or resolved? \_\_\_\_\_

Date of onset: \_\_\_\_\_

Date of treatment: \_\_\_\_\_

Method of treatment: \_\_\_\_\_

Medication: \_\_\_\_\_

Hospitalization: \_\_\_\_\_

Surgery: \_\_\_\_\_

Date of surgery: \_\_\_\_\_

Affected body area: \_\_\_\_\_

Outcome: \_\_\_\_\_

Doctor who performed the surgery  
or procedure: \_\_\_\_\_

File: [Patient]/current/patient\_info/[family member]/med\_history/[condition]/[date of  
condition]

PATIENT IMMUNIZATIONS

Last updated: \_\_\_\_\_

Patient name: \_\_\_\_\_

Immunization: \_\_\_\_\_

Date given: \_\_\_\_\_

Doctor: \_\_\_\_\_

Immunization: \_\_\_\_\_

Date given: \_\_\_\_\_

Doctor: \_\_\_\_\_

Immunization: \_\_\_\_\_

Date given: \_\_\_\_\_

Doctor: \_\_\_\_\_

Immunization: \_\_\_\_\_

Date given: \_\_\_\_\_

Doctor: \_\_\_\_\_

File: [Patient]/current/patient\_info/medical\_history/immunizations

PATIENT MEDICATIONS

Last updated: \_\_\_\_\_

Patient name: \_\_\_\_\_

Medication: \_\_\_\_\_

Medication start date: \_\_\_\_\_

Medication end date: \_\_\_\_\_

Condition being treated: \_\_\_\_\_

Medication strength (e.g., 800 mg): \_\_\_\_\_

Medication form (e.g., tablet): \_\_\_\_\_

Medication frequency  
(e.g., 3 times per day): \_\_\_\_\_

Medication duration (e.g., 10 days): \_\_\_\_\_

Medication directions: \_\_\_\_\_

Doctor prescribing this medication: \_\_\_\_\_

Date of prescription: \_\_\_\_\_

Pharmacy name and phone number: \_\_\_\_\_

Prescription number: \_\_\_\_\_

File: [Patient]/current/patient\_info/medical\_history/medications/[date]

EXHIBIT 6-9 DIET AND NUTRITION PLAN

PATIENT NUTRITION

Last updated: \_\_\_\_\_

Patient name: \_\_\_\_\_

Diet plan: \_\_\_\_\_

Dietary restrictions: \_\_\_\_\_

Dietary supplements: \_\_\_\_\_

File: [Patient]/current/patient\_info/medical\_history/Nutrition/[date]

INSURANCE AND EMPLOYER INFORMATION

Effective from: \_\_\_\_\_

Effective through: \_\_\_\_\_

Patient name: \_\_\_\_\_

Patient address: \_\_\_\_\_

Patient city, state, zip: \_\_\_\_\_

Patient home phone: \_\_\_\_\_

Patient cell phone: \_\_\_\_\_

Patient e-mail address: \_\_\_\_\_

Patient Social Security no. (optional): \_\_\_\_\_

Patient sex: \_\_\_\_\_

Patient primary language: \_\_\_\_\_

Guarantor name: \_\_\_\_\_

Guarantor address: \_\_\_\_\_

Guarantor city, state, zip: \_\_\_\_\_

Guarantor home phone: \_\_\_\_\_

Guarantor cell phone: \_\_\_\_\_

Guarantor e-mail address: \_\_\_\_\_

Guarantor Social Security no.: (opt.) \_\_\_\_\_

Primary insurance company name: \_\_\_\_\_

Primary insurance company claims address: \_\_\_\_\_

Primary insurance company claims address, city, state, and zip: \_\_\_\_\_

Primary insurance company claims phone number: \_\_\_\_\_

Primary insurance company claims fax number: \_\_\_\_\_

Primary insurance subscriber name: \_\_\_\_\_

Primary insurance subscriber address: \_\_\_\_\_

Primary insurance subscriber city, state, zip: \_\_\_\_\_

Primary insurance subscriber telephone: \_\_\_\_\_

Primary insurance subscriber employer name: \_\_\_\_\_

Primary insurance subscriber employer address: \_\_\_\_\_

Primary insurance subscriber employer city, state, and zip: \_\_\_\_\_

Patient relationship to subscriber: \_\_\_\_\_

Secondary insurance company name: \_\_\_\_\_

Secondary insurance company claims address: \_\_\_\_\_

Secondary insurance company claims address, city, state, and zip: \_\_\_\_\_

Secondary insurance company claims phone number: \_\_\_\_\_

Secondary insurance company claims fax number: \_\_\_\_\_

Secondary insurance subscriber name: \_\_\_\_\_

Secondary insurance subscriber address: \_\_\_\_\_

Secondary insurance subscriber city, state, zip: \_\_\_\_\_

Secondary insurance subscriber telephone: \_\_\_\_\_

Secondary insurance subscriber employer name: \_\_\_\_\_

Secondary insurance subscriber employer address: \_\_\_\_\_

Secondary insurance subscriber employer city, state, and zip: \_\_\_\_\_

Patient relationship to secondary subscriber: \_\_\_\_\_

Tertiary insurance company name: \_\_\_\_\_

Tertiary insurance company claims address: \_\_\_\_\_

Tertiary insurance company claims address, city, state, and zip: \_\_\_\_\_

Tertiary insurance company claims phone number: \_\_\_\_\_

Tertiary insurance company claims fax number: \_\_\_\_\_

Tertiary insurance subscriber name: \_\_\_\_\_

Tertiary insurance subscriber address: \_\_\_\_\_

Tertiary insurance subscriber city, state, zip: \_\_\_\_\_

Tertiary insurance subscriber telephone: \_\_\_\_\_

Tertiary insurance subscriber employer name: \_\_\_\_\_

Tertiary insurance subscriber employer address: \_\_\_\_\_

Tertiary insurance subscriber employer city, state, and zip: \_\_\_\_\_

Patient relationship to tertiary subscriber: \_\_\_\_\_

Employer information: \_\_\_\_\_

Patient employer name: \_\_\_\_\_

Patient employer address: \_\_\_\_\_

Patient employer city, state, zip: \_\_\_\_\_

Patient employer phone: \_\_\_\_\_

Guarantor employer name: \_\_\_\_\_

Guarantor employer address: \_\_\_\_\_

Guarantor employer city, state, zip: \_\_\_\_\_

Guarantor employer phone: \_\_\_\_\_

File: [Patient]/Insurance\_info/current \_\_\_\_\_

Note: provide a copy of the front and back of your current insurance card.

## PERSONAL PREFERENCES

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

1. Care means \_\_\_\_\_ to me.
2. I am seeking care because \_\_\_\_\_.
3. I believe \_\_\_\_\_ will cure me.
4. List life stressors that may be contributing to this illness: (for example)
 

My job	My parent	My marriage	Loss of loved one	My divorce	Loss of job
My child	Abusive relationship		My home	Drug or alcohol abuse	
5. To what level or degree do I want to participate in the decision-making process of my care?
6. I want a male/female doctor.
7. I care/don't care about the physician's primary language. I want that language to be \_\_\_\_\_.
8. I want my doctor to have been in practice \_\_\_\_\_ years.
9. I need this doctor to integrate with a team of doctors already working on my issue. (List the team members.)
10. I will bring the care team's contact sheet with me to this visit.
11. I need to communicate my expectation that the team communicate well among itself.
12. I expect my clinician to be an M.D., PA, Intern, etc. (See chapter 4 definitions.)

## ACCESS

1. I expect to be seen in \_\_\_\_\_ hours/days/weeks/months.
2. I expect the appointment booking encounter to take less than \_\_\_\_\_ minutes/hours/days/months.
3. I expect to wait no more than \_\_\_\_\_ minutes/hours/days/weeks for my health care service.
4. I expect to describe my symptoms/situations or tell my story to no more than \_\_\_\_\_ person(s). I have prepared a health record for this illness/exam and will share it with my doctor in a written format.
5. I expect to provide my personal and insurance information to no more than \_\_\_\_\_ person(s). I will bring my personal medical and family history in written form to all appointments when I am meeting with a new doctor.
6. I expect to pay \_\_\_\_\_ dollars for this service.
7. On a scale of zero to ten, my tolerance for redundancies and inefficiencies is \_\_\_\_ (zero being not at all tolerant and ten being extremely tolerant).
8. On a scale of zero to ten, my tolerance for timeliness is \_\_\_\_ (zero being not at all tolerant and ten being extremely tolerant).
9. I expect to spend \_\_\_\_\_ hours/days/weeks/months/lifetime healing this health issue OR I will ask my doctor how long I should expect to spend healing this issue.

## STANDARD CARE QUESTIONS

1. Do I really need the care they are proposing?
2. Do I really need the medications they are prescribing?
3. Will this treatment plan enhance my quality of life and wellness?
4. Years in practice?
5. Medical school graduate of \_\_\_\_\_
6. Internship performed at \_\_\_\_\_
7. Undergraduate degree in \_\_\_\_\_ from \_\_\_\_\_
8. Why did you become a \_\_\_\_\_ doctor?
9. How do you prepare for exams or procedures?
10. Will you read chart notes and documentation other doctors send to you before I arrive for my appointments?
11. What was the most exciting thing you learned recently that pertains to your career as a \_\_\_\_\_ doctor?
12. If we mutually agree that this relationship is a match, will you be committed to my care until I am well (or for my lifetime, in the case of a primary or family care situation) \_\_\_\_\_?
13. Have you ever had your hospital privileges revoked? If yes, where and why?
14. How would you feel if I were to need a second or third opinion pertaining to my health? How would you facilitate my request?
15. Considering I (the patient) track my medical history and will require my doctor(s) to read my history and share their charting with me, how did this doctor respond when I explained that? How will he/she share my chart notes with me? Via fax? USPS? Secure e-mail? Is the provider willing to share a photocopy of my record each day I am seen or remain in the hospital?
16. Understanding we are all humans and humans make mistakes, can you in general terms describe a mistake you made and what you did to rectify the situation?
17. Can you have three patients with my similar health status contact me as references?

18. Who will call me with test results? Will it be you, the doctor, or do you delegate that to a nurse?
19. Can I request that you call me with the results?
20. Will you mail, or fax my results to me?
21. How quickly will I get my results from you?
22. If I am in the hospital are you willing to book an appointment (or perform your rounds) at a mutually agreed upon time (e.g., not 5:45 a.m.) so that I can have my advocate present?  
Add you own questions.

#### COMMUNICATION AND REACTIONS

1. Was my initial reaction to this person a perception of a caring individual?
2. Did the person introduce himself or herself in a comfortable, approachable confident way?
3. How did the conversation flow?
4. Was the person a good listener?
5. Did he/she maintain good eye contact?
6. Did I understand what the person was saying?
7. Did the person ask well-rounded questions?
8. Did the questions expand beyond the scope of the one section of my body that is ailing? In a primary care situation, did the questions include my entire body, my emotional state, my family, and my life?
9. Did I leave feeling comfortable with this person?
10. Could I trust this person with my life?
11. Is there some sort of bond with this person?
12. Do I feel safe?
13. Is the communication easy and flowing? If I didn't understand something, did the person take the time to ensure that I understood?
14. Can this doctor comply with most or all of my standard expectations?
15. What does my intuition (or gut) tell me about this person?
16. Did this person do what he or she said they were going to do?

#### INSURANCE AND FINANCE

1. Is this doctor part of my insurance network?
2. Does this doctor plan to remain part of my insurance network? (If this doctor changes or cancels contracts with insurance companies on a regular basis, then you will either need to incur greater cost to continue care with this provider or need to seek care from another provider.)
3. Does this doctor have organized business practices?
4. What are the billing and collections policies?

File: [Patient]/current/clinical\_encounters/expectations

PREVISIT SOAP NOTES

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Provider: \_\_\_\_\_

Condition or chief complaint: \_\_\_\_\_

S: What do I need to tell the caregiver(s) (give them positive and negative thoughts, feelings, signs, and symptoms). Tell the story.

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O: What are the important and relevant physical changes since your last visit? Bring your lab test results.

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A: What do you believe is wrong? What do you feel needs attention? How is your life affected, and what are your priorities?

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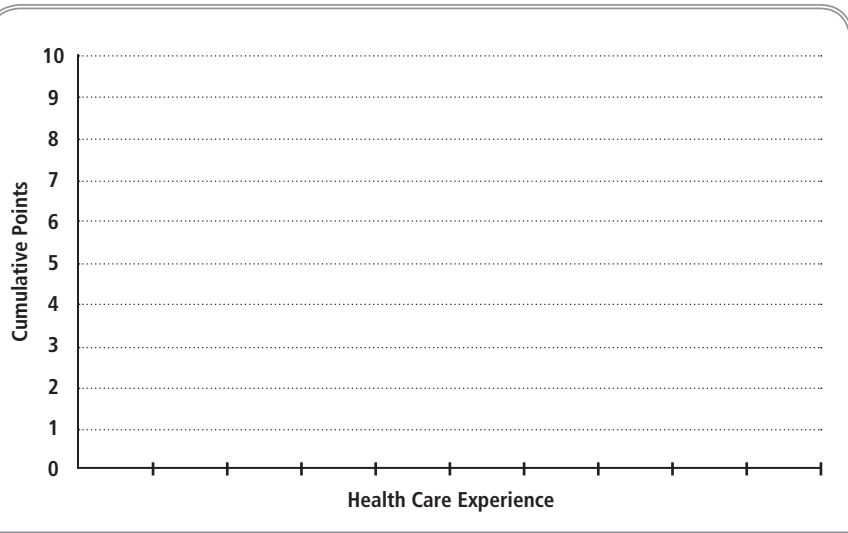
P: What is your plan? What are your questions, concerns, and criticisms? What is your ideal treatment path? How does this problem get resolved?

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My Standard Care Questions are: [copy from your preferences where applicable]

File: [Patient]/current/clinical\_encounters/previsit\_questions/[provider]/[visit date]



Scale	Anxiety Level
0 pts = no anxiety or neutral anxiety	0 to 4 = apprehension, concern, mild anxiety
1 pt = concern or apprehension/mild fear	5 to 7 = anger, frustration, sadness, fear
2 pts = fear/anger and frustration/sadness	8 to 10 = rage, irrationality, strong emotions
3 pts = rage and strong emotions/crying	
4 pts = irrational emotion and behaviors	

ENCOUNTER NOTES

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Provider: \_\_\_\_\_

Reason for encounter: \_\_\_\_\_

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

File: [Patient]/current/clinical\_encounters/notes/[provider]/[visit date]

EXHIBIT 6-15 COVER SHEET

Medical power of attorney	Yes	No
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Date signed:

Document location:

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Living will	Yes	No
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Date signed:

Document location:

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Do not resuscitate order (DNR)	Yes	No
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Date signed:

Document location:

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Organ donor	Yes	No
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Date signed:

Document location:

CLINICIAN CONTACTS

Last updated: \_\_\_\_\_

Last name: \_\_\_\_\_

First name: \_\_\_\_\_

Phone number: \_\_\_\_\_

Fax: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

File:[Patient]/current/contacts/doctors/[clinician last name]

PHARMACY CONTACTS

Last updated: \_\_\_\_\_

Pharmacy: \_\_\_\_\_

Phone number: \_\_\_\_\_

Fax: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

File: [Patient]/current/contacts/pharmacy/[pharmacy name]

CONTACTS FOR INSURANCE COMPANIES      Effective from: \_\_\_\_\_  
Effective through: \_\_\_\_\_

Primary insurance company name: \_\_\_\_\_  
Customer service phone number: \_\_\_\_\_  
Customer service fax: \_\_\_\_\_  
Customer service address: \_\_\_\_\_  
Customer service address: \_\_\_\_\_  
Customer service city, state, & zip: \_\_\_\_\_  
Claims phone number: \_\_\_\_\_  
Claims fax number: \_\_\_\_\_  
Claims address: \_\_\_\_\_  
Claims address: \_\_\_\_\_  
Claims city, state, & zip: \_\_\_\_\_  
Company Web address: \_\_\_\_\_  
Company e-mail address: \_\_\_\_\_

Secondary insurance company name: \_\_\_\_\_  
Customer service phone number: \_\_\_\_\_  
Customer service fax: \_\_\_\_\_  
Customer service address: \_\_\_\_\_  
Customer service address: \_\_\_\_\_  
Customer service city, state, & zip: \_\_\_\_\_  
Claims phone number: \_\_\_\_\_  
Claims fax number: \_\_\_\_\_  
Claims address: \_\_\_\_\_  
Claims address: \_\_\_\_\_  
Claims city, state, & zip: \_\_\_\_\_  
Insurance company Web address: \_\_\_\_\_  
Insurance company e-mail address: \_\_\_\_\_

Tertiary insurance company name: \_\_\_\_\_  
Customer service phone number: \_\_\_\_\_  
Customer service fax: \_\_\_\_\_  
Customer service address: \_\_\_\_\_  
Customer service address: \_\_\_\_\_  
Customer service address: \_\_\_\_\_  
Customer service city, state, & zip: \_\_\_\_\_  
Claims phone number: \_\_\_\_\_  
Claims fax number: \_\_\_\_\_  
Claims address: \_\_\_\_\_  
Claims address: \_\_\_\_\_  
Claims city, state, & zip: \_\_\_\_\_  
Insurance company Web address: \_\_\_\_\_  
Insurance company e-mail address: \_\_\_\_\_

File: [Patient]/current/contacts/ins\_Info/[Insurance\_Co\_name]

EMPLOYER CONTACT INFORMATION

Effective from: \_\_\_\_\_

Effective through: \_\_\_\_\_

Employer name: \_\_\_\_\_

Employer for whom? \_\_\_\_\_

Employer address: \_\_\_\_\_

Employer address: \_\_\_\_\_

Customer service address: \_\_\_\_\_

Employer city, state, & zip: \_\_\_\_\_

Employer phone: \_\_\_\_\_

Employer fax: \_\_\_\_\_

Employer human resource  
representative: \_\_\_\_\_

Employer human resource phone: \_\_\_\_\_

Employer e-mail: \_\_\_\_\_

Employer Web address: \_\_\_\_\_

File: [Patient]/current/contacts/employer/[employer\_name]

EMERGENCY CONTACT INFORMATION

Effective from: \_\_\_\_\_

Effective through: \_\_\_\_\_

Emergency contact name: \_\_\_\_\_

Emergency contact phone: \_\_\_\_\_

Emergency contact cell phone: \_\_\_\_\_

Emergency contact work phone: \_\_\_\_\_

Emergency contact address: \_\_\_\_\_

Emergency contact address: \_\_\_\_\_

Emergency contact city, state, & zip: \_\_\_\_\_

Emergency contact fax: \_\_\_\_\_

File: [Patient]/current/contacts/emergency/[contact last name]

CAREGIVER CONTACTS

Effective from: \_\_\_\_\_

Effective through: \_\_\_\_\_

Caregiver contact name: \_\_\_\_\_

Caregiver role: \_\_\_\_\_

Relationship to the guarantor: \_\_\_\_\_

Caregiver contact phone: \_\_\_\_\_

Caregiver cell phone: \_\_\_\_\_

Caregiver work phone: \_\_\_\_\_

Caregiver address: \_\_\_\_\_

Caregiver city, state, & zip: \_\_\_\_\_

Caregiver fax: \_\_\_\_\_

Caregiver schedule: \_\_\_\_\_

Caregiver company: \_\_\_\_\_

Caregiver company phone: \_\_\_\_\_

Caregiver company address: \_\_\_\_\_

Caregiver company address: \_\_\_\_\_

Caregiver company city, state, & zip: \_\_\_\_\_

Caregiver company fax: \_\_\_\_\_

File: [Patient]/current/contacts/care\_giver/{caregiver last name}

FACILITIES CONTACTS

Last updated: \_\_\_\_\_

Facility or hospital name: \_\_\_\_\_

Phone number: \_\_\_\_\_

Fax: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Facility Web address: \_\_\_\_\_

Facility e-mail address: \_\_\_\_\_

File: [Patient]/current/contacts/facilities/[facility name]