MORELAND COURTS
Sophisticated Living in an Architectural Landmark

MEDICAL INFORMATION

Name_____ **Address** _____

City _____ **State**____ **Zip Code**_____ **Home phone**_____

Work phone_____ **Cell phone** _____ **Email** _____

Date of Birth_____**Blood Type** _____

Please check all that apply:

Contact lenses _____ Dentures _____ Diabetic_____ Epileptic_____ Metal in body_____

Additional information: _____

Allergies to medications?____Please list _____

List all medical conditions:_____

_____

Next of kin or person to be notified in an emergency:

Name _____ Relationship _____ Phone _____

Email _____

Name _____ Relationship _____ Phone _____

Email _____

Name _____ Relationship _____ Phone _____

NOTE: EMERGENCY!

Medicare Beneficiary? Yes ___ No ___ **Medicare Part D?** Yes ___ No ___ **Medicare #** _____

Supplementary/Insurance Company _____ **Phone** _____

Group # _____ **Policy #** _____

Preferred Hospital: _____

Primary physician and/or medical treatment facility:

Physician Name _____ Phone _____

Medication List *Include over-the-counter, vitamins and prescription medications*

Rx Name	Dose