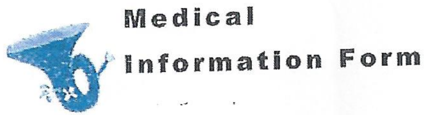
CUT



Medical Information Form

Name____________________

Address____________________

Phone____________________

Date of Birth ____/____/____ Male ☐ Female ☐

Social Security ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Medical History (Primary Medical Conditions)

____

____

☐ Asthma
☐ Emphysema
☐ Heart Failure
☐ AIDS
☐ Living Will
☐ Heart Problems
☐ Pacemaker
☐ Stroke
☐ Hepatitis
☐ DNRO
☐ Diabetes
☐ Seizure
☐ Hemophilia
☐ Anemia

Medications

____

____

Allergies to Medication

____

____

Physician

____

Phone

____

Hospital

____

Have you been a patient there? Yes ☐ No ☐

Medicare#____________________

Medicaid#____________________

Insurance____________________

Church____________________

Emergency Contact Information

Name & Relationship

____

Address____________________

Phone____________________

Name & Relationship

____

Address____________________

Phone____________________

Notes

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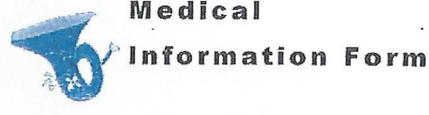
____

____

PLEASE PLACE IN LEFT SHOE



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CUT