

# Medical Information Card

*Regional  West  
Medical Center*

SCOTTSBLUFF, NE 69361 ~ 308.635.3711 ~ RWHS.ORG

Living Will:  Yes  No  
Donor:  Yes  No  
Durable Power of Attorney for Health Care?  Yes  No  
Have you ever had a reaction to anesthesia?  Yes  No

In an emergency please contact:  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

Full name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_  
SS # \_\_\_\_\_  
Date of birth: \_\_\_\_\_  
Citizenship: \_\_\_\_\_

## Existing Medical Conditions:

Heart Condition  Diabetes

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

Allergies: \_\_\_\_\_  
\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

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

## Current Medications/Dosages

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Insurance Information:

Company: \_\_\_\_\_

Policy No.: \_\_\_\_\_

Medicare  Medicaid

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_