[Do Not Remove Helmet Until I am Examined by a Doctor]

Date:_____

Name: _____

Home Phone: _____ Work Phone: _____

Address: _____ City: _____ State/Zip: _____

Date of Birth: _____Sex: _____Social Security #: _____

Drivers License #: _____State: _____

Employer/Phone: _____

Emergency Contact/Name: _____

Relationship: _____Phone/Home: _____Work: _____

Address: _____ City: _____ State/Zip: _____

Do Not leave an emergency message on an answering machine - contact must be made directly to a person

Health Insurance:

Company: _____

City/state: _____

Phone: _____

Policy/Group #: _____

Vehicle Insurance:

Company: _____

City/state: _____

Phone: _____

Policy/Group #: _____

Allergies To Medications:

1. _____
2. _____
3. _____
4. _____

Medications Now Being Used:

1. _____
2. _____
3. _____
4. _____

Blood Type: _____

Blood Pressure: _____

Family Doctor: _____

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Wear Contact Lenses: Yes: ____No:____

Wear Dentures: Yes: ____No:____

Special Notes/Health Problems:

_____

_____

_____

_____

[attach office card if available]

Sign here to authorize emergency medical treatment by a [doctor, hospital, EMT] when direct authorization cannot be given:

_____