Health Care Information

PERSONAL INFORMATION			
First Name	(Nickname)	Last Name	DOB or Age
Street Address		City, State, ZIP	
Preferred Language	Phone Number	Emergency Contact Information	
Parent/Legal Representative		Parent/Legal Representative Phone/Email	
Insurance Information		Pharmacy Information (most commonly used)	
Primary Care Provider/Contact Information		Specialty Care Providers/Contact Information	
Communication Support Needed			

Note: Information on this form may not be complete

Health Conditions

Medications

Allergies and Dietary Restrictions

Medical/Assistive Devices and/or Service Animal

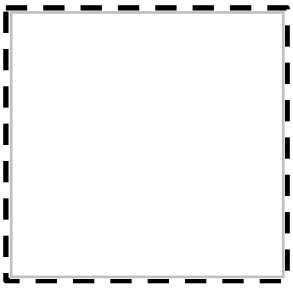
Advance Care Planning (check all that apply)

- ☐ HEALTH CARE ADVANCE DIRECTIVE OR LIVING WILL – Location, if known: _____
- ☐ POWER OF ATTORNEY– Location, if known: _____
- ☐ DO NOT RESUSCITATE (DNR) ORDER – Location, if known: _____
- ☐ PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST, MOLST OR POST)
- ☐ PSYCHIATRIC ADVANCE DIRECTIVE – Location, if known: _____

IMPORTANT – Health Care Person-Centered Profile on Reverse Side

Health Care Person-Centered Profile

What Matters to Me



Please call me

1. What people appreciate about me

2. Who and what is important to me

3. How to best support me

This Health Care Person-Centered Profile was completed by: ☐ Me ☐ Someone else

Name and relationship: