HCM

Thank you for choosing HCM
HillCountryMemorial.org
Phone 830-997-4353

Date Completed:_____

Emergency Information

Name:_____Phone:_____

Address:_____

Date of Birth:_____ Blood Type:_____

Primary Language:_____Religion:_____

Primary Care Physician:_____Phone:_____

1. Emergency Contact:_____
2. Emergency Contact:_____
3. Emergency Contact:_____

In an emergency this person may secure my residence:

Name:_____Phone:_____

I have a medical power of attorney: YES NO

Designee of my medical power of attorney:_____Phone:_____

Medication Allergies:_____

Other Allergies:_____

Illnesses or Medical Conditions:_____

I have: (circle all that apply)

Pacemaker Internal Defibrillator False Teeth

Hearing Aids Contact Lenses Artificial Limbs

I am currently being treated for: (circle all that apply)

Heart Disease High Blood Pressure Stroke Cancer

Diabetes Epilepsy Kidney Disease

Other major surgeries or conditions not referenced above:_____

_____

Disabilities:_____

Vision or hearing difficulties:_____