The Medical Center of Central Georgia
mccg.org

Your Contact Information

NAME | PHONE

ADDRESS | DATE OF BIRTH

CITY/STATE/ZIP | ☐ LIVING WILL ☐ ORGAN DONOR

Primary Care Physician

NAME | PHONE

ADDRESS | FAX

CITY/STATE/ZIP | EMAIL

Primary Emergency Contact

NAME | PHONE

ADDRESS | PHONE

CITY/STATE/ZIP | EMAIL

Secondary Emergency Contact

NAME | PHONE

ADDRESS | PHONE

CITY/STATE/ZIP | EMAIL

Primary Insurance Company

NAME | PHONE

ADDRESS | POLICY NUMBER

CITY/STATE/ZIP | SUBSCRIBER NUMBER

Secondary Insurance Company

NAME | PHONE

ADDRESS | POLICY NUMBER

CITY/STATE/ZIP | SUBSCRIBER NUMBER

Advocate/Health Care Proxy

NAME | PHONE

ADDRESS | PHONE

CITY/STATE/ZIP | RELATIONSHIP

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Medications

PRESCRIPTION NAME	DOSE	TIMES PER DAY	BEGIN	END

REASON

PRESCRIPTION NAME	DOSE	TIMES PER DAY	BEGIN	END

REASON

PRESCRIPTION NAME	DOSE	TIMES PER DAY	BEGIN	END

REASON

PRESCRIPTION NAME	DOSE	TIMES PER DAY	BEGIN	END

REASON

PRESCRIPTION NAME	DOSE	TIMES PER DAY	BEGIN	END

REASON

PRESCRIPTION NAME	DOSE	TIMES PER DAY	BEGIN	END

REASON

PRESCRIPTION NAME	DOSE	TIMES PER DAY	BEGIN	END

REASON

PRESCRIPTION NAME	DOSE	TIMES PER DAY	BEGIN	END

REASON

PRESCRIPTION NAME	DOSE	TIMES PER DAY	BEGIN	END

REASON

PRESCRIPTION NAME	DOSE	TIMES PER DAY	BEGIN	END

REASON

Allergies

ALLERGEN	REACTION
ALLERGEN	REACTION
ALLERGEN	REACTION
ALLERGEN	REACTION
ALLERGEN	REACTION

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Family Medical History (parents, grandparents, siblings, children)

NAME	RELATIONSHIP	CONDITION
NAME	RELATIONSHIP	CONDITION
NAME	RELATIONSHIP	CONDITION
NAME	RELATIONSHIP	CONDITION
NAME	RELATIONSHIP	CONDITION
NAME	RELATIONSHIP	CONDITION
NAME	RELATIONSHIP	CONDITION
NAME	RELATIONSHIP	CONDITION

Emergency Numbers

RESCUE	POISON CONTROL
FIRE	OTHER
POLICE	OTHER

Primary Care Physician

HEALTH CARE PROVIDER/FACILITY	PHONE
ADDRESS	FAX
CITY/STATE/ZIP	EMAIL
HEALTH CARE PROVIDER/FACILITY	PHONE
ADDRESS	FAX
CITY/STATE/ZIP	EMAIL
HEALTH CARE PROVIDER/FACILITY	PHONE
ADDRESS	FAX
CITY/STATE/ZIP	EMAIL
HEALTH CARE PROVIDER/FACILITY	PHONE
ADDRESS	FAX
CITY/STATE/ZIP	EMAIL

Primary Care Physician (continued)

HEALTH CARE PROVIDER/FACILITY | PHONE
ADDRESS | FAX
CITY/STATE/ZIP | EMAIL

HEALTH CARE PROVIDER/FACILITY | PHONE
ADDRESS | FAX
CITY/STATE/ZIP | EMAIL

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CITY/STATE/ZIP | EMAIL

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Important Health Care Events—symptoms, diagnoses, surgeries, treatments, etc.

DATE (MM/DD/YYYY)	DESCRIPTION

Important Health Care Events—symptoms, diagnoses, surgeries, treatments, etc. (continued)

DATE (MM/DD/YYYY)	DESCRIPTION

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Vital Statistics History

DATE	HEIGHT/WEIGHT	BLOOD PRESSURE	LDL/HDL	TRIGLYCERIDES

Vital Statistics History

GLUCOSE	PSA (Male)	PAP (Female)	MAMMOGRAM (Female)	OTHER