# FACE SHEET

LAST UPDATED
*UPDATE EVERY 6 MONTHS*

NAME

DOB | LAST 4 DIGITS OF SOCIAL SECURITY #

ADDRESS | CITY | STATE | ZIP CODE

MOBILE PHONE | WORK PHONE

## IN CASE OF EMERGENCY | HEALTH CARE AGENT WITH POWER OF ATTORNEY

NAME | RELATIONSHIP

PRIMARY PHONE | MOBILE | EMAIL

ADDRESS | CITY | STATE | ZIP CODE

## IN CASE OF EMERGENCY | HEALTH CARE AGENT WITH POWER OF ATTORNEY

NAME | RELATIONSHIP

PRIMARY PHONE | MOBILE | EMAIL

ADDRESS | CITY | STATE | ZIP CODE

## CODE STATUS

DO YOU HAVE A P.O.L.S.T, M.O.L.S.T OR DNR FORM? Y / N | DONOR Y / N

LOCATION OF ADVANCED DIRECTIVE FORM(S)

LIVING WILL ON FILE AT

DOCUMENTS ARE UPLOADED TO MYCHART Y / N | HOSPITAL NAME

## PROCEDURE

SURGERY DATE

HOSPITAL OR SURGICAL LOCATION | PHONE

SURGEON

Who will be the main support person responsible for transportation and providing pre- and post-surgery assistance?

NAME | MOBILE PHONE

## PRIMARY INSURANCE

## SECONDARY INSURANCE

## DRUG PLAN

 

SMOKE: Y / N DRINK: Y / N

ALLERGIES

PHARMACY NAME LOCATION PHONE

## MEDICATION(S)

LIST

IN PATIENT PORTAL Y / N

## KNOWN CONDITIONS, EVENTS, AND PREVIOUS SURGERIES

LIST

IN PATIENT PORTAL Y / N

## PHYSICIAN

DATE OF LAST VISIT PHONE

ADDRESS CITY STATE ZIP CODE

## SPECIALIST

DATE OF LAST VISIT PHONE

ADDRESS CITY STATE ZIP CODE

## SPECIALIST

DATE OF LAST VISIT PHONE

ADDRESS CITY STATE ZIP CODE

 