



INFORMATION REQUIRED IN AN EMERGENCY

State Form 46213 (10-93)

CLIENT INFORMATION

Name of client

Address (*number and street, city, state, ZIP code*)

Telephone number

Date of birth

Social Security number

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY DURING THE DAY

Name

Relationship

Address (*number and street, city, state, ZIP code*)

Telephone number

FAMILY DOCTOR

Name

Address (*number and street, city, state, ZIP code*)

Telephone number

MEDICAL INSURANCE

Policy number

Disabilities or health problems:

Medication:

Allergies (*Medications and other*):

Do you wear:

Contacts

Dentures

I hereby authorize Blind and Visually Impaired Services to obtain emergency medical and / or hospital services.

Signature of client

Date signed