Vial of Life

Personal Medical History for Claremont Retirement Village

Name:____

Address: 7041 Bent Tree Blvd **Room #**: ____________________
Columbus, OH 43235

Phone Number: ______________________ Work: ________________ Cell:______________

Date of Birth: _____________________ Birthplace: ___________________ Sex: ________

<u>Health Insurance</u>: (**Please attach copy of Medicare and secondary insurance cards, front and back)

Primary Insurance: ____________________________ Group #__________________________

Subscriber Name: ______________________________ Subscriber #: ____________________

Secondary Insurance: ___________________________ Group #__________________________

Subscriber Name: ______________________________ Subscriber #: ____________________

Hospital Preference: ____

DNR on File: Yes No

Living Will on File Yes No

Doctor Name	Phone	Address

Medication/Dose	Medication/Dose
1.	**5.**
2.	**6.**
3.	**7.**
4.	**8.**

Medication Allergies: ____

____

Over…

In case of Emergency contact…

Name	Phone	Home Address
	H)	
	W)	
Relationship: ____________________________	C)	
Name	**Phone**	**Home Address**
	H)	
	W)	
Relationship: ____________________________	C)	
Name	**Phone**	**Home Address**
	H)	
	W)	
Relationship: ____________________________	C)	

Previous Illnesses:

1. ____ Date: ______________
2. ____ Date: ______________
3. ____ Date: ______________
4. ____ Date: ______________

Previous Surgeries:

1. ____ Date: ______________
2. ____ Date: ______________
3. ____ Date: ______________

Funeral Arrangements By: ____

Phone number: ____

My Estate will be handled by: ____

Phone number: ____

Date Form Completed: ____