Conditions I am being treated for:
(please print clearly)

1. _____

2. _____

3. _____

4. _____

5. _____

My name is:

_____

Insurance #:

_____

Medicare #:

_____

Address:

_____

Doctor:

_____

Doctor's Phone #:

_____

In case of emergency contact:

_____

Phone #:

_____

Work #:

_____

Cell #:

_____

Carry this in your wallet at all times.

Gila Regional Medical Center

PLANETREE

1313 32nd St., Silver Cilty NM • 575/538-4000
www.grmc.org

Allergies & Sensitivities

Medication or Food	Reaction

Medications I am taking regularly or as needed (cross out if discontinued)

Medication/Dosage	Reaction

(please print clearly)

Medications I am taking regularly or as needed (cross out if discontinued)

Patient Name: _____

Name of Medication & Strength *Brand name, generic name, over-the-counter, herbals, vitamins, injections, eye drops, creams*	**Dose** *How Many, tabs, puffs, etc.*	**Frequency** *How often*