# **Medical Information at a Glance**

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| **Name** |  |
| **Social Security Number** |  |
| **Date of Birth** |  |
| **Health Insurance Company Name** |  |
| **Health Insurance Policy Number** |  |
| **Dental/Vision Insurance Company Name** |  |
| **Dental Insurance Policy Number** |  |
| **Known Allergies** |  |
| **Surgical History** |  |
| **Health Conditions & Current Medications With Dosages** |  |
| **Primary Care Physician Name and Contact** |  |
| **Specialist Name and Contact Information** |  |