Montage At Mission Hills

HOMEOWNERS ASSOCIATION

FILE OF LIFE EMERGENCY INFORMATION FORM

This form is for the use of Montage at Mission Hills residents to provide key personal life-saving information to assist emergency medical response personnel in understanding your personal health and medical needs during an emergency. Please 1.) complete the form and 2.) place the form in a sealable plastic bag or container 3.) place the bag inside your refrigerator or affixed to the front of side of your refrigerator in a visible area. (This form is available as an electronic fill-in form at www.montageatmissionhills.org/forms/ .

Personal Information

Name	Date Form Completed	Preferred Language

	Male		Female			Single		Married		Divorced		Widowed
Gender			Date of Birth		Marital Status							

Montage Address	Street	City	State	Zip

Home Phone	Work Phone	Cell Phone

Medicare Number	Secondary HMO / Insurance Company	Policy Number

Do you have an advanced Directive (Living Will, Durable Power of Attorney for Health Care or similar document? Yes ☐ No ☐

If so, who did you name to make healthcare decisions for you (if anyone) or where can a copy of the document be found?

POA / Health Care Contact Name	Phone	Document Location

Emergency Contact Name	City/State	Relationship	Phone
Emergency Contact Name	City/State	Relationship	Phone
Primary Care Physician	City/State		Phone
Secondary Physician	City/State		Phone
Clergy Name	City/State		Phone
Pet Names		Pet Sitter Name	Phone

Medical Information

Where are hospital records located?									
Where do you keep medications?									
Drug Allergies. If yes please list	Yes		No		Food Allergies. If yes please list	Yes		No	

Medical Information

Normal Blood Pressure		Height		Weight	

Dentures	Yes		No			Wear Contacts	Yes		No		Wear Glasses	Yes		No	
Hearing aids	Yes		No			Use Oxygen	Yes		No						

Current Medications (Include prescription and over the counter drugs, vitamins and herbal supplements)

Drug Name	Dosage / Time	Drug Purpose

Medical History (What medical problems/physical disabilities do you have? For example heart problems, diabetes, high blood pressure, etc.)

Past Surgeries (Type and date)

Signature	Date