OSAGE NATION HEALTH SYSTEM
A Culture of Caring

Vial of L.I.F.E. = Life-Saving Information For Emergencies

Patient information: **Primary Language: _____**

Name:	**Male/Female:**
Date of Birth:	**Last 4 digits of SS #:**
Address:	
City:	**State:** **Zip Code:**
Home Phone ( )	**Cell Phone ( )**

Health Information:

Primary Medical Problems:

Any disabilities: No ____ Yes____, Describe:

Previous Medical Problems: (Check all that apply):
Heart Disease___ High Blood Pressure/Hypertension____ Low Blood Pressure____ Stroke___

Glaucoma___ Asthma____ Emphysema____ Hemophilia_____ Anemia_____ HIV/AIDS_____

Diabetes____ Hypoglycemia (low blood sugar)____ Cancer_____ Other_____

Do you have a pacemaker: No____ Yes____, Model: _____

Blood Type: _____ Other implants? No____ Yes____, Describe:

Dentures: Yes _____ No____ Hearing Aids: Yes____ No____ Glasses: Yes____ No_____
Prescription Medications (List here or attach list):

Where are your medications kept:

Allergies to mediations (list):

Other Allergies (list):
Do you have an Advance Directive/Living Will? No_____ Yes_____, Location? **Enclose a copy here if you are able.**

<u>Primary Care Provider/Emergency Contact Information:</u>

Primary Care Provider:	**Phone Number:**
Hospital Preference:	**Have you been a patient there? Yes, ___ No__**
Emergency Contact: **Name:**	**Telephone #:**

I certify that the information on this form is accurate and up to date. I also understand that emergency personnel may rely on this information. I agree not to hold emergency personnel responsible for inaccurate or out-of-date information.

Date Completed/Updated_____**Signature**_____