

# MEDICAL AND HEALTH CARE DOCUMENT ORGANIZER

A TOOL TO HELP MAINTAIN AND LOCATE IMPORTANT HEALTH CARE AND MEDICAL PAPERS FOR  
CAREGIVERS AND CARE RECEIVERS

Pennsylvania Department of Aging  
Long Term Living Public Education and Outreach Division

This booklet contains personal and private information. Please keep in a safe place.  
Please inform another trusted individual of the location of this document.

**Personal Information for:** \_\_\_\_\_  
**Address** \_\_\_\_\_  
**City** \_\_\_\_\_ **State** \_\_\_\_\_ **ZIP** \_\_\_\_\_  
**Telephone** \_\_\_\_\_

**EMERGENCY CONTACTS**

Legal Name \_\_\_\_\_  
Maiden Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Place of Birth \_\_\_\_\_  
Marital Status \_\_\_\_\_

Name \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Mobile or other \_\_\_\_\_

(For the following information, please record if available and location where kept)

Marriage Certificate or License \_\_\_\_\_

Driver's License Number \_\_\_\_\_

Name \_\_\_\_\_

Divorce Record(s) \_\_\_\_\_

Home Phone \_\_\_\_\_

Spouse's Death Certificate \_\_\_\_\_

Work Phone \_\_\_\_\_

Adoption Certificate \_\_\_\_\_

Mobile or other \_\_\_\_\_

Naturalization Certificate \_\_\_\_\_

Military ID \_\_\_\_\_ Military Retirement Benefits \_\_\_\_\_ Branch of Service \_\_\_\_\_  
Contact Number \_\_\_\_\_

Has a Living Will? \*\*\* YES or NO

Has An Advanced Directive or Health Care Power of Attorney \*\*\* YES or NO

\*\*\*copies of these documents should be kept with this form and given to healthcare professionals if treatment is needed

## Medical Records/Health Care Information

Primary Physician \_\_\_\_\_ Telephone \_\_\_\_\_

Physician's Address \_\_\_\_\_

Secondary Physician \_\_\_\_\_ Telephone \_\_\_\_\_

Physician's Address \_\_\_\_\_

Specialists (for example: Ophthalmologists, Cardiologists, Nephrologists, Rheumatologists, Oncologists)

Physician \_\_\_\_\_ Telephone \_\_\_\_\_ Specialty \_\_\_\_\_

Physician \_\_\_\_\_ Telephone \_\_\_\_\_ Specialty \_\_\_\_\_

Physician \_\_\_\_\_ Telephone \_\_\_\_\_ Specialty \_\_\_\_\_

### Current Medications:

**Medication Name** \_\_\_\_\_ Prescribing Physician \_\_\_\_\_

Used to treat \_\_\_\_\_ Strength \_\_\_\_\_ Color \_\_\_\_\_ Shape \_\_\_\_\_

Form \_\_\_\_\_ (tablet, capsule, liquid, suppository, etc)

How Much to Take \_\_\_\_\_ How Often and When To Take \_\_\_\_\_

How Long to Take \_\_\_\_\_ (for example, an antibiotic for 10 days)

Possible Side Effects \_\_\_\_\_

Other Cautions \_\_\_\_\_

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Other Cautions \_\_\_\_\_

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How Long to Take \_\_\_\_\_ (for example, an antibiotic for 10 days)  
Possible Side Effects \_\_\_\_\_  
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Other Cautions \_\_\_\_\_

NON PRESCRIPTION MEDICATIONS/VITAMINS/SUPPLEMENTS

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**Medical Conditions:**

I have the following diagnoses, conditions or illnesses:

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Medical or Specialized Equipment Used:

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I have been hospitalized for the following conditions or reasons

Date of Hospitalization	Reason for Hospitalization	Name of Hospital

I have had the following surgeries:

Surgery	Date	Hospital

Known Allergies:

Medication or Drug Allergies	Reactions or Symptoms

Food or Other (for example, latex, bee stings) Allergies	Reactions or Symptoms

Immunizations received:      Flu\_\_\_\_\_      Pneumococcal \_\_\_\_\_      Tetanus\_\_\_\_\_

Other Important Information:

Preferred Hospital #1 \_\_\_\_\_  
Preferred Hospital #2 \_\_\_\_\_  
Preferred Pharmacy \_\_\_\_\_

Other Notes: (include cognitive problems, any assistance needed with daily activities, hearing or vision problems or dietary restrictions)

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Concerns or Safety Measures

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## Insurance Information

### Health Insurance:

Medicare Number \_\_\_\_\_ Effective Date – Part A \_\_\_\_\_

Effective Date – Part B \_\_\_\_\_

Medicare Prescription Plan (Part D) \_\_\_\_\_ Effective Date \_\_\_\_\_

Supplemental Medicare Insurance (HMO, Advantage, PPO, Special Needs Plans, Medical Savings Accounts, etc)

Plan Name \_\_\_\_\_

Policy Number \_\_\_\_\_

Group Number \_\_\_\_\_

Effective Date \_\_\_\_\_

Plan Telephone Number \_\_\_\_\_

Plan Address \_\_\_\_\_

Long Term Care Insurance

Plan Name \_\_\_\_\_

Policy Number \_\_\_\_\_

Plan Telephone Number \_\_\_\_\_

Plan Address \_\_\_\_\_

Social Security Number \_\_\_\_\_ Social Security Office Number \_\_\_\_\_

Veteran's Claim Number \_\_\_\_\_ Veteran's Office Number \_\_\_\_\_

Other Health Insurance: (catastrophic illness, hospital insurance, disability insurance, etc.)

Name \_\_\_\_\_ Type \_\_\_\_\_ Telephone \_\_\_\_\_

Name \_\_\_\_\_ Type \_\_\_\_\_ Telephone \_\_\_\_\_

**Life Insurance:**

Company Name \_\_\_\_\_ Policy Number \_\_\_\_\_ Face Value \_\_\_\_\_ Paid Up \_\_\_\_\_

Company Name \_\_\_\_\_ Policy Number \_\_\_\_\_ Face Value \_\_\_\_\_ Paid Up \_\_\_\_\_

Company Name \_\_\_\_\_ Policy Number \_\_\_\_\_ Face Value \_\_\_\_\_ Paid Up \_\_\_\_\_

**Burial Policy/Irrevocable Burial Account/Funeral Plan/Prepaid Funeral**

Name of Bank or Company, Funeral Home \_\_\_\_\_

Location \_\_\_\_\_ Account Number (if any) \_\_\_\_\_

Contact number \_\_\_\_\_

Where can paperwork be found \_\_\_\_\_

**Cemetary Plot or Property**

Name \_\_\_\_\_ Location \_\_\_\_\_

Where can Certificate or deed by found \_\_\_\_\_

Notes

**NOTE: IMPORTANT FINANCIAL INFORMATION KEPT SEPARATELY**

## Other Insurance

Homeowners

Name of Company\_\_\_\_\_ Policy Number\_\_\_\_\_ Contact Number\_\_\_\_\_

Location of policy papers\_\_\_\_\_

Location of Deed\_\_\_\_\_

Auto

Name of Company\_\_\_\_\_ Policy Number\_\_\_\_\_ Contact Number\_\_\_\_\_

Location of policy papers\_\_\_\_\_

Location of Title or sales agreement\_\_\_\_\_

Renters

Name of Company\_\_\_\_\_ Policy Number\_\_\_\_\_ Contact Number\_\_\_\_\_

Location of policy papers\_\_\_\_\_

Location of Lease\_\_\_\_\_

**Know the location of important personal health information such as Living Wills, Power of Attorney, Insurance Cards and policies, and other documents. These should be given to healthcare professionals in the event of an emergency.**