PATIENT PATH
NEW YORK CITY

(917) 283 - 2765
Shlomit@PatientPathNYC.com
www.PatientPathNYC.com

Preparing for Hospital Stay - Medical History and Contact Information

Patient Information

Full Name: _____

Date of Birth: _____

Gender Identity: _____

Phone Number: _____

Email Address: _____

Primary Care Physician

Name: _____

Phone Number: _____

Email: _____

Advanced Directives

- ▢ Health Care Proxy
- ▢ Power of Attorney
- ▢ DNI
- ▢ HIPAA Release
- ▢ DNR
- ▢ MOLST

Medications

Recommendation - mark all medications prescribed by the same provider in one **color**

Medication / Supplement	Dosage (mg, etc)	Frequency	Purpose	Special Instructions

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Current Treating Specialist

Specialty	Provider Name	Phone Number	Email

Medical Conditions and Diagnoses

Medical Condition / Treatment / Diagnosis	Year	Resolved or Ongoing

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Allergies

(List any known allergies, including drug, food, or environmental allergies)

Allergy	Reaction

Surgeries

Surgery	Reason	Year	Hospital

Health Insurance Information

Insurance Provider: _____

Policy Number: _____

Group Number: _____

Primary Insurance Holder's Name:_____

Primary Insurance Holder's Date of Birth:_____

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Contact Information for Daily Communication

(List individuals you wish to be communicated with regarding your care. These may include family members, caregivers, or other designated contacts. First contact will be primary contact)

Name	Relationship to Patient	Phone Number	Email Address	Preferred Contact Method (Phone/Email)

Remember to bring copies of your -

- ID Card
- Insurance Card
- Vaccination record
- Advanced Directives
    - Living Will
    - Health Care Proxy Form
    - DNR order

Anything else you wish your medical team to know?

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