

RIO ADHC/ADC EMERGENCY INFORMATION FORM

CLIENT

ADMIT DATE: _____

LAST NAME _____ FIRST NAME _____ M.I. _____

DOB _____ SS# _____ CDL OR CA ID# _____

ADDRESS _____ PHONE# _____

CITY, STATE, ZIP _____

SEX: MALE FEMALE ETHNICITY: CAUCASIAN BLACK HISPANIC ASIAN NATIVE AMER OTHER UNKNOWN

MARITAL STATUS: M S W D SEP PRIOR CLIENT? ___ yes ___ no If yes, when? _____

RESPONSIBLE PARTY

LAST NAME _____ FIRST NAME _____ RELATION _____

ADDRESS _____ PHONE# _____

CITY, STATE, ZIP _____

PAGER # _____ CELLULAR # _____

EMPLOYER _____ PHONE# _____

LAST NAME _____ FIRST NAME _____ RELATION _____

ADDRESS _____ PHONE# _____

CITY, STATE, ZIP _____

PAGER # _____ CELLULAR # _____

EMPLOYER _____ PHONE# _____

ADDITIONAL EMERGENCY CONTACTS:

NAME _____ REL TO CLIENT _____ PHONE# _____

NAME _____ REL TO CLIENT _____ PHONE# _____

DOCTOR _____ PHONE# _____ FAX# _____

ADDRESS _____ CITY _____ ZIP _____

PRIMARY DIAGNOSIS _____ ONSET DATE _____

Additional diagnoses: _____

MEDICATIONS _____

ALLERGIES _____

FOOD RESTRICTIONS _____