

# Lincoln Emergency Medical Services

## Patient Information Form

Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
Birth Date \_\_\_\_\_ Phone # \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ ST. \_\_\_\_\_ Zip \_\_\_\_\_

Medical History \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Hospital \_\_\_\_\_ Primary Doctor \_\_\_\_\_

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_