

ER SMART CARD

Quick Access Card Application

Please return application to: Wellington Regional Medical Center
Attn: Emergency Department • 10101 Forest Hill Boulevard • Wellington, FL 33414
or fax to: 561-472-2506

OR fill in form fields and click the "submit" button below for electronic submission.



*First name _____ *Last name _____ Middle _____

Marital Status _____ *Social Security Number _____

*Birth date _____ *Male *Female

*Address _____

*City _____ *State/Zip _____

*Home phone _____ Cell phone _____ Email address _____

Emergency Contact _____ Phone number _____

Employer _____

Insurance company _____ Phone number _____

Subscriber (name) _____ Policy number _____ Group number _____

Primary physician _____ Phone number _____

Medications

Drug Name	Dosage	Times/day

Allergies

If any, please list allergy, type and reaction:

Operations/Hospitalizations

If none, check here
Surgery/Reason Date or Year Hospital

Vaccinations/Immunizations

Tetanus date: _____
Pneumonia vaccination date: _____
Flu vaccination: _____
Pediatric immunizations: _____
Other vaccinations with dates: _____

Social

Are you a smoker? No Yes Packs/day: _____
Alcohol: Drinks per day _____ per week: _____

Advance Directives (e.g., organ donations, DNR)

*Required fields in red

Family History

Illness

- Diabetes
- Stroke
- Heart disease
- Blood clots in lungs or legs
- High blood pressure
- High cholesterol
- Osteoporosis (weak bones)
- Recurrent miscarriage
- Infertility
- Birth defects
- Drinking or drug problems
- Breast cancer
- Colon cancer
- Ovarian cancer
- Uterine cancer
- Mental illness/depression
- Alzheimer's Disease
- Other _____

Personal Medical History

Major Illness

- Asthma
- Pneumonia/lung disease
- Tuberculosis
- Mitral valve prolapse
- Heart attack/heart problems
- High blood pressure
- Stroke
- Blood clots in lungs or legs
- Kidney infections/stones
- Sexually transmitted disease
- HIV/AIDS
- Thyroid disease
- Diabetes
- Eating disorders
- Depression/anxiety
- Arthritis/joint pain/back problems
- Collagen vascular disease (lupus)
- Cancer
- Reflux/hiatal hernia/ulcers
- Hepatitis/jaundice/liver disease
- Gallbladder disease
- Colitis/Crohn's Disease
- Anemia
- Blood transfusions
- Migraine headaches
- Seizures/convulsions/epilepsy
- Other _____

I acknowledge and take responsibility for the accuracy of this information and understand that Wellington Regional Medical Center and its agents will retain this information as confidential medical information.

*Patient Signature: _____
(Signature required—please sign if mailing or faxing. If submitting electronically, please type in name.)
Date: _____

