

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



*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

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

Personal Medical History

Major Illness

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

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: _____

