# Emergency Information

**Contact Information:**

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|---|---|---|---|---|---|
| Name: | | Address: | | | |
| | | City: | | State: | |
| ***Phone Numbers:*** | | ***Emergency Contact:*** | | | |
| Home: | | Name: | | | |
| Employer: | | Phone: | | | |
| Work: | | Mobile: | | | |
| Alt: | | City: | | State: | |
| SSN# | | Relation: | | WADL# | |

**Motorcycle Insurance Information:**

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|---|---|---|---|---|---|
| Carrier: | | Agent: | | | |
| Policy Number: | | Address: | | | |
| Office Phone: | | City | | State: | |

**Medical Insurance:**

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|---|---|---|---|---|---|
| Company Name: | | Address: | | | |
| Policy #s | | City: | | State: | |
| Subscriber No.: | | Second opinion req'd? | ☐ Yes | ☐ No | |
| Do you have a living will? | ☐ Yes ☐ No | Organ Donor? | ☐ Yes | ☐ No | |
| Religion: | | | | | |

Sign here to authorize emergency medical treatment by a Doctor, Hospital, EMT when direct authorization can not be given: _____.

## Medical Information:

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|---|---|---|---|---|---|
| Family Doctor/Facility: | | Address: | | | |
| Office Phone: | | City: | | State: | |
| Alt. Number: | | | | | |

**Blood Type:** _____

***Special Medical Conditions:***

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***Current Medications:***

| Medication: | Dosage: | Frequency: |
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***Drug Allergies:***

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***Allergies:***

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***Surgeries:***

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