MEDICAL
BINDER

MEDICAL
INFORMATION

PRIMARY DOCTOR	PREFERENCES
Name	Emergency Contact:
Address	
Phone	Hospital:
Email	Pharmacy:
DENTIST	**PERSONAL INFO**
Name	D.O.B:
Address	Blood Type:
Phone	Weight:
Email	Height:
PEDIATRICIAN	**MEDICAL CONDITIONS & ALLERGIES**
Name	
Address	
Phone	
Email	
VETERINARIAN	
Name	
Address	
Phone	
Email	
OTHER	
Name	
Address	
Phone	
Email	

INSURANCE		INSURANCE	
Company:	Phone:	Company:	Phone:
Policy:	Copay:	Policy:	Copay:

MEDICAL
INFORMATION

DOCTOR:

Specialty:	
Phone:	Email:
Address:	

DOCTOR:

Specialty:	
Phone:	Email:
Address:	

DOCTOR:

Specialty:	
Phone:	Email:
Address:	

DOCTOR:

Specialty:	
Phone:	Email:
Address:	

MEDICAL
INFORMATION

STARTING WEIGHT: _____ DATE: _____

DATE	WEIGHT	BMI	WAIST	HIPS	NOTES