MY PREFERRED PROVIDERS

PRIMARY CARE NAME: PHONE: _____ **CARDIOLOGY** NAME: _____ PHONE:____ **OTHER** NAME: PHONE: ____ **OTHER** NAME: _____ PHONE: ____ PREFERRED PHARMACY NAME: _____

PHONE: ______



PATIENT NAME

McLAREN

MY PREFERRED FACILITY

EMERGENCY CONTACT INFORMATION

NAME: ____

PHONE:_____

RELATIONSHIP:_____

CURRENT PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS				
NAME	DOSE		FREC	UENCY
PLEASE LIST MEDICATION ALLERGIES	RECENT BLOOD PRESSURE READINGS			
	DATE	BLOOD	PRESSURE	PULSE
	1	1		