Vantage Point
— Behavioral Health —

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EMERGENCY CONTACT AND PRIMARY CARE PHYSICIAN INFORMATION

I _____ give my consent to contact the individuals included on this form (emergency contacts) in case of emergencies :

_____ _____
Date Signature of Patient under 16

Emergency Contacts :

Name(s) :_____

Address:

_____
Street Apt # City State Zip Code

Phone Number (s): A.M: _____ P.M. : _____ Email: _____

Relationship to Client: ☐ Legal Guardian ☐Foster Parent ☐ Social Worker ☐Other: _____

Name(s) : _____

Address :

_____
Street Apt # City State Zip Code

Phone Number (s): A.M: _____ P.M. : _____ Email: _____

Relationship to Client : ☐ Legal Guardian ☐ Foster Parent ☐ Social Worker ☐ Other: _____

☐ **I authorize to give medical information to these contacts in case of emergency.**

☐ **I don't have a second emergency contact (Only for children)**

Primary Care Physician Contact Form

Physician Name: _____ Phone Number: _____

Address :

_____

Street Apt # City State Zip Code

Allergies: _____

Known Medical Conditions:

_____

☐ **I do not have a Primary Care Physician at present. I will find one and arrange to have a physical.**

☐ **I am unable to afford physician health care and will not be able to arrange for a physical at this time.**

I agree that the information above has not changed since the last date signed.

_____	_____	_____
Client/Legal Guardian Signature	*Printed Name*	*Date*
_____	_____	_____
Client/Legal Guardian Signature	*Printed Name*	*Date*