# Emergency Treatment Information:

I am experiencing extreme headache resulting from a Migraine attack. I am not a "drug seeker," and have brought a form from my doctor verifying my diagnosis and treatment information.

## Registration Information:

______________________________________________ ______________
Full Name Date of Birth

______________________________________________________________
Address City State Zip Code

______________________________ ______________________________
Home Phone Office Phone

______________________________________________________________
Employer

______________________________________________________________
Emergency Contact Relationship Phone Number

_____________________ _____________________ _________________
Insurance Carrier Patient Insurance ID number Group/Policy Number

## Physician Information:

______________________________________________ ______________
Physician Name Physician Phone Number

## Treatment Information:

Duration: This attack began: ____________________________________________

On a scale of 0 - 10, I currently rate my pain at ________.
I am also experiencing other Migraine symptoms as circled: neck pain • nausea • vomiting • diarrhea • sensitivity to light • sensitivity to sound • dizziness • ______________________

To treat this Migraine attack, I have taken these medications:

______________________________________________________________
Medication Dosage Time Taken

______________________________________________________________
Medication Dosage Time Taken

______________________________________________________________
Medication Dosage Time Taken

**Other Medications Taken** (not for Migraine)**:**

______________________________________________________________

______________________________________________________________

______________________________________________________________

**Known Allergies**: _____________________________________________

______________________________________________________________

__________________________________________ __________________
Patient Signature Date

**Note to patients***: It's a good idea to make copies of the front and back of your insurance card(s) to have with copies of this form. Most hospitals want copies of the card, and it will save you time during registration to take a copy with you.*

This form created and provided by Teri Robert
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