

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	

Treatment Information:

Duration: This attack began: _____

On a scale of 1 - 10, I currently rate my pain at _____.

I am also experiencing other Migraine symptoms as circled:

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: _____

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.