Patient Information Form

Patient Name

Patient Contact Number

Street Address

Email Address

Door Code

Primary Contact

Primary Contact Number

Secondary Contact

Secondary Contact Number

Knox Tag Number

Knox Serial Number

Knox Box Location

Medical History

- [ ] None / Denies
- [ ] Hypertension
- [ ] Asthma
- [ ] Cancer
- [ ] Cardiac
- [ ] CVA
- [ ] Diabetic
- [ ] Animals on Premise
- [ ] Other

Medical History

- [ ] Falls
- [ ] Infectious Disease
- [ ] Psychiatric
- [ ] Respiratory
- [ ] Seizure
- [ ] Disabled
- [ ] Hearing / Vision Impaired
- [ ] Medical Allergies
- [ ] Other

I understand that I am responsible for returning the Knox box when I am finished using it. I understand that I will be responsible for replacement cost of the knox box if it is damaged or lost.

Signature:

Data Entry:

- ○ Entered
- ○ Returned
- ○ Date

Updated by: