

DocuBank Healthcare Directive Registry Enrollment Form

A. MEMBER INFORMATION

Information in **BOLD** appears on your card. *Email address is required for online account access.

Prefix: _____ **Name:** _____ Home Phone: _____
Address: _____ Work Phone: _____
City, State, Zip: _____ DOB (optional): _____
_____ Email*: _____

Trust Name and Creation Date (Optional. 57 character max, to appear on your card):

Attorney: _____ Firm name: _____

B. SERVICE SELECTION

One Year \$45	Five Years \$145 (Savings of \$80)
With Medication List storage: One Year \$55	Five Years \$185

C. PAYMENT METHOD

Paid through Attorney Credit Card Check (payable to DocuBank*)

Credit Card Number _____ Exp Date _____
Name on Credit Card _____ Card Type _____

D. EMERGENCY CONTACTS

(Optional) If information is not available now you can call us to update after you receive your card.

FIRST CONTACT

Name: _____ **Relationship:** _____
Home#: _____ **Work#:** _____ **Cell#:** _____
Email: _____ **Contact Note:** _____

SECOND CONTACT

Name: _____ **Relationship:** _____
Home #: _____ **Work #:** _____
Cell#: _____ **Email:** _____

THIRD CONTACT

Name: _____ **Relationship:** _____
Home #: _____ **Work #:** _____
Cell#: _____ **Email:** _____

PHYSICIAN INFORMATION

Name: _____ **Phone#:** _____ **Fax#*:** _____
(if fax # is provided a fax may be sent to the Dr.)

E. OPTIONAL CARD INFO

Please number up to 4 selections. (All selections may not fit on your card.)

Allergies ___ Penicillin ___ Sulfa ___ Latex ___ Peanuts _____

Permanent Medical Conditions (Do **not** list medications here. See section F.)

___ Alzheimer's ___ Arthritis ___ Asthma ___ Diabetes ___ Heart Disease ___ High Blood Pressure
___ Cancer survivor ___ Stroke history _____

Card Note (45 char. max) _____ (omitted if storing medication list, see section F)

Organ Donor form is included with your directives? ___ **Yes** ___ **No**

F. MEDICATION LIST

(Optional)

You can store a list of your medications. Because medications may change frequently, there is an additional fee(see section B)

Is a Medication List (signed and dated) included? ___ **Yes** ___ **No** (If Yes, a note appears on your card.)

G. MEMBER STATEMENT

I have completed an advance directive document(s) (e.g. living will, health care power of attorney, HIPAA authorization, and/or organ donation information) of my own free will and have chosen to enroll in DocuBank to help make my document(s) available when requested. To ensure prompt access, I authorize that my document(s), emergency contact and health information stored with DocuBank be accessible to anyone who provides the member number and PIN on my card. I will notify DocuBank promptly of changes in any of my stored information, and also of the revocation or replacement of my document(s). I understand that DocuBank is not responsible for the validity or accuracy of any information stored by DocuBank, including the health information that also appears on my card. I understand that: by accepting my card I have verified and confirmed the accuracy of all information on the card before carrying it; by providing a fax number for my physician, I am granting DocuBank permission to fax an enrollment notification enabling this physician to obtain my directives; that DocuBank does not provide legal advice; and that I may cancel this service in writing by written request to DocuBank.

Signature: _____ Date: _____