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:	Email Address*:
	DOB *(optional):*
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**

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 / **Physician** (*if fax# is provided, a fax may be sent to Dr.)

Name:	Relationship:	Name:	
Home #:	**Work #:**	Phone:	Fax*:
Cell #:	Email:	**First Contact Note:**	

Second Contact / **Third Contact**

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

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 at time of renewal.* **Is a Medication List (signed and dated) included**? ☐ **Yes** ☐**No**

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.

Check 1 or none:

☐ I elect to have DocuBank send an email notice to my emergency contacts upon my enrollment and whenever my documents are requested.

☐ I elect to have DocuBank send an email notice to my emergency contacts upon my enrollment only.

Signature: _____ Date: _____