VIAL OF LIFE FORM

SHARP HEALTHCARE 1-800-827-4277

General Information

Name: ______________________________ Date: ______________

Address: ______________________________ Phone: ______________

City, State: ______________________________ Zip Code: ______________

Date of Birth: __ __ /__ __/__ __ Gender: Male ___ Female____

Height: ____ Weight: ____ Marital Status: Single___ Married___ Widowed____ Divorced____

Health Insurance Information

Social Security No. (last 4 digits):__ __ __ __ Medicare Number: ______________

Primary Insurance Company: ______________ Policy Number: ______________

Secondary Insurance Company: ______________ Policy Number: ______________

Have you filled out an Advance Directive for Health Care Form? Yes___ No___

If yes, name of health care agent: ______________ Phone: ______________

Have you requested a Do Not Resuscitate order? Yes__ No __ If Yes, enclose/attach.

Notify in Case of Emergency

Name: ______________ Relationship: ______________ Phone: ______________

Name: ______________ Relationship: ______________ Phone: ______________

Name: ______________ Relationship: ______________ Phone: ______________

Others Living in the Home

Name: ______________ Relationship: ______________ Phone: ______________

Name: ______________ Relationship: ______________ Phone: ______________

Name: ______________ Relationship: ______________ Phone: ______________

Pet Name/Type ______________ Pet Sitter Name: ______________ Phone: ______________

Medical Information

Primary Physician: ______________ Phone: ______________

Secondary Physician: ______________ Phone: ______________

Specialty Physician: ______________ Phone: ______________

Location of Hospital Records: ______________________________

Normal Blood Pressure: ______________

Drug Allergies (specify): ______________________________

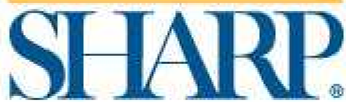
Food Allergies (specify): ______________________________

What medical problems/physical disabilities do you have? ______________________________

____

List past surgeries (type and date): ______________________________

____



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Do you:

wear dentures? Yes___ No___ wear glasses? Yes___ No___

wear contacts? Yes___ No___ wear a hearing aid? Yes___ No___

use oxygen? Yes___ No___

Where do you keep your medications? ____

Current Medications (list prescription, over the counter drugs, vitamins, herbal supplements, eye drops, etc.)

Name: ____________________________ Dosage: _______________ Times: _________________

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Name: ____________________________ Dosage: _______________ Times: _________________

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