DOCUBANK ENROLLMENT FORM

MEMBER INFORMATION *Email address is required for online access.*			
Name:			DOB:
Address:		Primary Phone:	
		Alternate Phone:	
City, State, Zip		**Email:**	
Trust Name:			

FIRM INFORMATION NAME OF ATTORNEY AND/OR FIRM PROVIDING THIS MEMBERSHIP	
Firm Name:	Attorney Name:

MEMBERSHIP INFORMATION

LENGTH: (select only one) ❑ 1 year: $55 ❑ 5 years: $175

PAYMENT: ❑ Attorney ❑ Check ❑ Credit Card (see details below)

CC#: _____ Exp: _____ Name on Card: _____ CSV: _____

EMERGENCY CONTACTS *(Optional) Information can be added or updated when you receive your card. Information in bold is on the card.*			
Primary Contact:	Relationship:	Email:	
Home #:	**Work #:**	**Cell #:**	**Note:**

Second Contact:	Relationship:	Email:
Home #:	Work #	Cell#

Third Contact:	Relationship:	Email:
Home #:	Work #:	Cell #:

MEDICAL INFORMATION If fax number is provided for physician, doctor may receive a fax with your access information		
Physician Name:	Phone:	Fax*:

MEDICAL ALLERGIES *(Optional) These allergies will appear on your card for quick reference by physicians*

❑ Penicillin ❑ Sulfa ❑ Latex ❑ Peanuts ❑ Shellfish ❑ Aspirin ❑ Tree Nuts ❑ Eggs ❑ Naproxen

❑_____ ❑_____ ❑_____ ❑_____

PERMANENT MEDICAL CONDITIONS *(Optional) Do NOT list medications here.*

❑ Arthritis ❑ Asthma ❑ Heart Disease ❑ High Blood Pressure ❑ Hypertension ❑ Vision Loss ❑ Hearing Loss

❑ Cancer (type)_____ (stage)_____ ❑_____ ❑_____ ❑_____

ADDITIONAL CARD NOTE *(45 char. max)* _____

MEDICATION LIST *(Optional) If a medication list is included, a note will appear on your emergency card.* ***Add*** *one now or* ***online at any time.***

MEMBER STATEMENT: And optional alerts for emergency contacts

I have chosen to enroll myself in DocuBank to help make personal emergency information available promptly. 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 the DocuBank member card. All advance directives have been completed of my own free will and I will notify DocuBank promptly of changes in any of the stored information, and also of the revocation or replacement of any 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 the member card; by accepting a card I have verified and confirmed the accuracy of all information on the card before carrying or distributing it; by providing an email address I am authorizing DocuBank to email me; 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; I am granting DocuBank permission to alert my contacts as indicated on this form; if I provide an email address for the emergency contact(s), I am granting DocuBank permission to contact these persons and provide them with member information as indicated by my selection of such permission below. I understand that my DocuBank membership includes the optional use of the DocuBank SAFE, which provides online access to my personal documents. I understand that DocuBank does not provide legal advice; and that I may cancel this service at any time by written request to DocuBank.

EMERGENCY CONTACT ALERTS (Check 1 or none) Alerts will be sent to all contacts for whom you have provided an email address.

❑ **I want all the email addresses I provided for my emergency contact**s to receive a personalized alert email from DocuBank whenever my card is used and an introductory email when my membership is activated.

❑ **I want the email addresses I provided for my emergency contacts** to receive an email only when my membership is activated.

Signature _____ Date _____