

ENROLLMENT FORM

Follow the instructions at the bottom of this page to set up your DocuBank Emergency Card

SERVICE SELECTION

(Select only one)

DocuBank ICE

COLLEGE STUDENTS

1 year 5 years

REFERRAL SOURCE (Optional: Name of firm and/or professional that referred you to DocuBank)

Firm/Provider Name: _____

MEMBER INFORMATION

Name: _____ DOB: (MM/DD/YY) _____ / _____ / _____

CONTACT INFO

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Email: _____

ALLERGIES: Penicillin Sulfa Latex Peanuts _____ _____

PERMANENT MEDICAL CONDITIONS (Do not list medications)

Diabetes _____ _____ _____

Card Note (45 char. max) _____

EMERGENCY CONTACTS (optional) If information is not available now, you can update it when you receive your card.

1ST CONTACT

Name: _____ Relationship: _____ Name: _____
Home #: _____ Work #: _____ Phone #: _____ Fax #: _____
Cell #: _____ Email: _____ 1ST CONTACT Note: _____

DOCTOR (Primary Care) If fax # is given, doctor may receive fax with access information

2ND CONTACT

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

3RD CONTACT

ADDITIONAL DOCUMENTS STORED (Notation will appear on member's card)

Medication List HIPAA Release

College/University: _____

MEMBER STATEMENT: I have chosen to enroll myself in DocuBank to help make my 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; I am granting DocuBank permission to alert my contacts as indicated on this form; if I provide an email address or cell phone for the emergency contact(s), I am granting DocuBank permission to contact these persons and provide them with member information. 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 in writing at any time by written request to DocuBank.

SIGNATURE: _____ **DATE:** _____

TO ENROLL: Send this completed form, your payment and the relevant emergency documents as described for each service (e.g. HIPAA Release, Health Care Power of Attorney and more). You can also include an additional Emergency Information Form and Medication List, which are available at docubank.com/forms.

MAIL TO:

DocuBank
P.O. Box 629
Springfield PA 19064

EMAIL TO:

joindocubank@docubank.com

FAX TO:

610-667-1483

QUESTIONS?

Call 1-866-829-0993 or
visit DOCUBANK.COM