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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