ENROLLMENT FORM

PROTECTING YOUR FAMILY IS SIMPLE: Follow the instructions at the bottom of this page.

SERVICE SELECTION

(Select only one)

Minors MatterCHILDREN UNDER 18

○1 year ○5 years

CONTACT INFO (For Minors Matter, please provide address of member's parent/guardian) Address: City: State: Zip: Home #: Cell #: Email: ALLERGIES: Penicillin Sulfa Latex Peanuts Diabetes Diabetes Card Note (45 char. max) EMERGENCY CONTACTS (optional) If information is not available now, you can update it when you receive your card. DOCTOR (Primary Care) Name: Relationship: Name: Name: Relationship: Name: Name: Relationship:	REFERRAL SO	URCE (Optional: N	ame of firm and/c	or professional that re	eferred you to Do	ocuBank)
Name: CONTACT INFO (For Minors Matter, please provide address of member's parent/guardian) 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. DOCTOR (Primary Care) Name: Relationship: Name: Name: Phone #: Phon	Firm/Provid	er Name:				
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ADDITIONAL DOCUMENTS STORED (Notation will appear on member's card) Medication List Health Insurance Information MEMBER STATEMENT: I have chosen to enroll my minor child or ward in DocuBank to help make their emergency information available promptly. To ensur prompt access, I authorize that my child or ward's, 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 documents 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 the contacts as indicated on this form; if I provide an email 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: [parent/legal guardian]			Relationship:			Relationship:
MEMBER STATEMENT: I have chosen to enroll my minor child or ward in DocuBank to help make their emergency information available promptly. To ensure prompt access, I authorize that my child or ward's, 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 documents 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 the contacts as indicated on this form; if I provide an email 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: [parent/legal guardian]	Home #:		Work #:		Home #:	Work #:
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TO ENROLL: Send this completed form, your payment and the relevant emergency documents (e.g. Guardianship Forms, Temporary Health Care Power of Attorney, and more). You can also include an additional Emergency Information Form and Medication List, which		•				

MAIL TO: DocuBank P.O. Box 629 Springfield PA 19064

are available at docubank.com/forms.

EMAIL TO: joindocubank@docubank.com

FAX TO: 610-667-1483

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