Date Completed _____

# VIALOFLIFE.com 1-888-724-1200

| FIRST NAME | INITIAL | LAST NAME | SOCIAL SECURITY NUMBER |
|---|---|---|---|
| | | | |

| STREET | CITY | STATE | ZIP | TELEPHONE |
|---|---|---|---|---|
| | | | | |

| DATE OF BIRTH | MALE/FEMALE | HEIGHT | WEIGHT | HAIR COLOR | EYE COLOR | BLOOD TYPE | RELIGION |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

| List hearing difficulties | DENTURES UPPER LOWER | UNABLE TO SPEAK ☐ |
|---|---|---|
| List vision difficulties | NATIVE LANGUAGE IF NOT ENGLISH | |

Identifying Marks

Current Medical Conditions

Past Medical Conditions

Current Medications: Dosage and Frequency

Allergies to Medications

Doctors Name and Telephone Number

Last Hospitalization

Special Instructions such as health directives, etc...

Health Insurance Policy

Emergency Contact Notification - Name - Address - Phone - Relationship

**PLACE ON REFRIGERATOR DOOR - PLEASE PRINT CLEARLY**