FILE OF LIFE

FILE OF LIFE EMERGENCY INFORMATION FORM

This form provides emergency medical personnel with life-saving information to assist them in understanding your personal health & medical needs in an emergency. You need to 1.) complete the form; 2.) place the form in a seal-able plastic bag or container; 3.) place the bag inside your refrigerator or affix it to the front or side of refrigerator in a visible area; and, 4.) put a File of Life logo on your front door. (The File of Life logo and an electronic version of this form are available for downloading at the website by copying this link www.montageatmissionhills.org/forms/ into your browser.) Insert cursor in form fill-in box and type. Tab between boxes. Or handwrite.

Personal Information

Name	Date Form Completed	Preferred Language

	Male		Female			Single		Married		Divorced		Widowed
Gender				Date of Birth			Marital Status					

Montage Address	Street	City	State	Zip

Home Phone	Work Phone	Cell Phone

Medicare Number	Secondary HMO / Insurance Company	Policy Number

Do you have an advanced Directive (Living Will, Durable Power of Attorney for Health Care or similar document? Yes ☐ No ☐

If so, who did you name to make healthcare decisions for you (if anyone) or where can a copy of the document be found?

POA / Health Care Contact Name	Phone	Document Location

Emergency Contact Name	City/State	Relationship	Phone
Emergency Contact Name	City/State	Relationship	Phone
Primary Care Physician	City/State		Phone
Secondary Physician	City/State		Phone
Clergy Name	City/State		Phone
Pet Names		Pet Sitter Name	Phone

Medical Information

Where are hospital records located?									
Where do you keep medications?									
Drug Allergies. If yes please list	Yes		No		Food Allergies. If yes please list	Yes		No	

This form may be filled out electronicaally or by hand. A copy of this form is available at https://montageatmissionhills.org/forms

Medical Information

Normal Blood Pressure					Height				Weight							
Dentures	Yes		No		Wear Contacts	Yes		No		Wear Glasses	Yes		No			
Hearing aids	Yes		No		Use Oxygen	Yes		No								

Current Medications (Include prescription and over the counter drugs, vitamins and herbal supplements)

Drug Name	Dosage / Time	Drug Purpose

Medical History (What medical problems/physical disabilities do you have? For example heart problems, diabetes, high blood pressure, etc.)

Past Surgeries (Type and date)

Signature	Date

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