



## Patient Information Form



*The information in this LifeMed™ System is protected by law. Information contained herein is provided by the owner. Neither the issuer nor LifeMed, Inc., their officers, directors or employees assume any responsibility as to the accuracy or authenticity of the patient data. Owner agrees to hold issuer and LifeMed, Inc. harmless from the consequences of any errors arising from usage of this card or its data.*

Member ID _____	Address _____
Card No _____	Address2 _____
Salutation _____	City _____
First Name _____	State _____
Middle Name _____	Country _____
Last Name _____	Postal Code _____
Suffix _____	PhoneNumber _____
Birth Date _____	PhoneNumber 2 _____
Gender _____	PhoneNumber 3 _____
Height _____	Email Address _____
Weight _____	Internet Access _____
Blood Type _____	Transportation _____
Marital Status _____	Primary Language _____
Faith _____	Translator _____
Prosthetics _____	Learning _____
Vision _____	Power Of Attorney _____
Hearing _____	Advance Directives _____
Speech _____	Advance Directives Location _____
Mobility _____	Advance Directives Agent _____
Organ Donor _____	Physician Orders for Life-Sustaining Treatment _____

\_\_\_\_\_  
Date Patient/Patient's Authorized Signature

\_\_\_\_\_  
If other than patient, indicate relationship Witness Witness