



ParentYourParents.com

Vital Information for: _____

Date: _____

Completing the information in this packet with your loved one(s) is a non-threatening way to start having some of those difficult, but necessary conversations. We strongly recommend completing the information in this packet and storing it in a safe, yet accessible place.

We suggest you update the appropriate sections when/if major changes occur in your loved ones health, financial situation and/or final wishes. Once the forms are complete you will have most, if not all, the necessary information in the event of an emergency, or in the event your loved one can no longer communicate such information on his/her own.



Important Personal Information

Personal Information

Full Name: _____ Date of Birth: _____

Social Security Number: ____/____/____

Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Relationship: _____

Phone: _____ Cell Phone: _____ Other: _____

Emergency Contact: _____ Relationship: _____

Phone: _____ Cell Phone: _____ Other: _____

Health Insurance Information

Name of Provider: _____ Effective Date: _____

Provider Address: _____ Provider Phone: _____

Member Number: _____ Group/Policy Number: _____

Benefits: _____ Co-Pay: _____ Benefits: _____ Co-Pay: _____

Medicare Information

Name of Provider: _____ Effective Date: _____

Provider Address: _____ Provider Phone: _____

Member Number: _____ Group/Policy Number: _____

Benefits: _____ Co-Pay: _____ Benefits: _____ Co-Pay: _____

Secondary Health Insurance Information

Name of Provider: _____ Effective Date: _____

Provider Address: _____ Provider Phone: _____

Member Number: _____ Group/Policy Number: _____

Benefits: _____ Co-Pay: _____ Benefits: _____ Co-Pay: _____

Medicaid Information

Name of Provider: _____ Effective Date: _____

Provider Address: _____ Provider Phone: _____

Member Number: _____ Group/Policy Number: _____

Benefits: _____ Co-Pay: _____ Benefits: _____ Co-Pay: _____



Important Personal Information (cont.)

Military Information

Division of Service: _____ Date of Acceptance: _____
Date of Discharge: _____ Location of Discharge Papers : _____
Do you have Military Records: _____ Location of Records: _____
Military Insurance: _____ Military ID Number: _____

Legal Information

Medical Power of Attorney: YES or NO Executor Name: _____
Executor Phone #: _____
Durable Power of Attorney: YES or NO Executor Name: _____
Executor Phone #: _____
Do you have a Healthcare Proxy: YES or NO Executor Name: _____
Executor Phone #: _____
Advanced Directive or Living Will: YES or NO Representative Name: _____
Representative Phone #: _____
Do you have any of the following:
DNR(do not resuscitate): _____ No Tube Feedings: _____ Do Not Hospitalize: _____
Comfort Care Only: _____ No Antibiotics or IV Care: _____
If you answered yes to any of the above is this part of your advanced directive? _____
Location of Documents: (safety deposit box, attorney, file,) _____
Number of Box: _____ Name of Financial Institution: _____

Appearance/Activities of Daily Living Information

Personal Appearance

Feet:	Good Condition_____	May Require Medical Attention_____
Hands:	Good Condition_____	May Require Medical Attention_____
Skin Condition:	Good Condition_____	May Require Medical Attention_____
Teeth:	Good Condition_____	May Require Medical Attention_____
Vision:	Good Condition_____	May Require Medical Attention_____
Hearing:	Good Condition_____	May Require Medical Attention_____
Communication:	Good Condition_____	May Require Medical Attention_____

Activities of Daily Living (ADL)

Bathing:	Independent_____	Dependent_____	Needs Assistance_____
Dressing:	Independent_____	Dependent_____	Needs Assistance_____
Grooming:	Independent_____	Dependent_____	Needs Assistance_____
Eating:	Independent_____	Dependent_____	Needs Assistance_____
Transfers:	Independent_____	Dependent_____	Needs Assistance_____
Ambulation:	Independent_____	Dependent_____	Assistive Device:_____

Independent Activities of Daily Living (IADL)

Preparing Meals:	Independent_____	Dependent_____	Assistive Device:_____
Arranging Travel:	Independent_____	Dependent_____	Assistive Device:_____
Climbing Stairs:	Independent_____	Dependent_____	Assistive Device:_____
Housekeeping:	Independent_____	Dependent_____	Assistive Device:_____
Shopping:	Independent_____	Dependent_____	Assistive Device:_____
Walking:	Independent_____	Dependent_____	Assistive Device:_____
Managing Finances:	Independent_____	Dependent_____	Assistive Device:_____
Managing Meds:	Independent_____	Dependent_____	Assistive Device:_____
Socializing:	Independent_____	Dependent_____	Assistive Device:_____

Continence

Urinating:	Continent:_____	Incontinent:_____	Occasionally Incontinent:_____
Stool:	Continent:_____	Incontinent:_____	Occasionally Incontinent:_____

Appearance/Activities of Daily Living Information (cont.)

Personal

Dietary Preferences: _____

Religious Preference: _____

Daily Routines: _____

Likes/Dislikes: _____

Medical History/Doctor Information

Doctor Information

Doctors Name: _____ Field: _____

Address: _____ Phone #: _____

Doctors Name: _____ Field: _____

Address: _____ Phone #: _____

Doctors Name: _____ Field: _____

Address: _____ Phone #: _____

Doctors Name: _____ Field: _____

Address: _____ Phone #: _____

Doctors Name: _____ Field: _____

Address: _____ Phone #: _____

Doctors Name: _____ Field: _____

Address: _____ Phone #: _____

Medical History

Allergies: (List all known allergies) _____

Current Medical Conditions (List all Diagnosis)

Condition: _____ When Diagnosed _____

Condition: _____ When Diagnosed _____

Condition: _____ When Diagnosed _____

Condition: _____ When Diagnosed _____

Condition: _____ When Diagnosed _____

Condition: _____ When Diagnosed _____

Psychiatric Diagnosis: _____ When Diagnosed _____

Have you Had any of the following:(yes or no and date)

Flu Shot _____/_____ Pneumonia Shot _____/_____

Tetanus Shot _____/_____ Zostavax Vaccine(Shingles) _____/_____



Medications/Herbs/Vitamins Information

Medications

Drug Name: _____ Dosage: _____

Instructions: _____

Drug Name: _____ Dosage: _____

Instructions: _____

Drug Name: _____ Dosage: _____

Instructions: _____

Drug Name: _____ Dosage: _____

Instructions: _____

Drug Name: _____ Dosage: _____

Instructions: _____

Drug Name: _____ Dosage: _____

Instructions: _____

Drug Name: _____ Dosage: _____

Instructions: _____

Vitamins and Herbs

Name: _____ Dosage: _____

Instructions: _____

Name: _____ Dosage: _____

Instructions: _____

Name: _____ Dosage: _____

Instructions: _____

Hospital and Surgery Information

Previous Hospitalizations (Include Date and Hospital)

Reason: _____ Month/Year: _____

Hospital/Address: _____

Reason: _____ Month/Year: _____

Hospital/Address: _____

Reason: _____ Month/Year: _____

Hospital/Address: _____

Reason: _____ Month/Year: _____

Hospital/Address: _____

Reason: _____ Month/Year: _____

Hospital/Address: _____

Reason: _____ Month/Year: _____

Hospital/Address: _____

Previous Surgeries (Include Date and Hospital)

Type: _____ Month/Year: _____

Hospital/Address: _____

Type: _____ Month/Year: _____

Hospital/Address: _____

Type: _____ Month/Year: _____

Hospital/Address: _____

Type: _____ Month/Year: _____

Hospital/Address: _____

Type: _____ Month/Year: _____

Hospital/Address: _____

Type: _____ Month/Year: _____

Hospital/Address: _____

Type: _____ Month/Year: _____

Hospital/Address: _____

Financial Information

Financial Information (Credit Cards, Loans, etc.)

Financial Institution: _____ Account #: _____

Access Code/Pin #: _____ Is Account Accessible On-Line? _____

On-Line User Name: _____ Password: _____

Financial Institution: _____ Account #: _____

Access Code/Pin #: _____ Is Account Accessible On-Line? _____

On-Line User Name: _____ Password: _____

Financial Institution: _____ Account #: _____

Access Code/Pin #: _____ Is Account Accessible On-Line? _____

On-Line User Name _____ Password _____

Location of Documents: (safety deposit box, attorney, file,) _____

Number of Box: _____ Name of Financial Institution: _____

Mortgage Information

Financial Institution: _____ Account #: _____

Access Code/Pin #: _____ Is Account Accessible On-Line? _____

On-Line User Name: _____ Password: _____

Financial Institution: _____ Account #: _____

Access Code/Pin #: _____ Is Account Accessible On-Line? _____

On-Line User Name: _____ Password: _____

Financial Institution: _____ Account #: _____

Access Code/Pin #: _____ Is Account Accessible On-Line? _____

On-Line User Name: _____ Password: _____

Location of Documents: (safety deposit box, attorney, file,) _____

Number of Box: _____ Name of Financial Institution: _____

Financial Information (cont.)

Current Assets(Banks, Savings, Stocks, Bonds, Investments, Retirement Plans)

Financial Institution: _____ Loan #: _____

Access Code/Pin #: _____ Is Account Accessible On-Line? _____

On-Line User Name: _____ Password: _____

Financial Institution: _____ Loan #: _____

Access Code/Pin #: _____ Is Account Accessible On-Line? _____

On-Line User Name: _____ Password: _____

Financial Institution: _____ Loan #: _____

Access Code/Pin #: _____ Is Account Accessible On-Line? _____

On-Line User Name: _____ Password: _____

Location of Documents:(Safety Deposit, Attorney, File, etc.) _____

Number of Box: _____ Name of Financial Institution: _____

Insurance Policies

Company Name: _____ Account #: _____

Access Code/Pin # _____ Is Account Accessible On-Line? _____

On-Line User Name _____ Password _____

Company Name: _____ Account #: _____

Access Code/Pin # _____ Is Account Accessible On-Line? _____

On-Line User Name _____ Password _____

Company Name: _____ Account #: _____

Access Code/Pin # _____ Is Account Accessible On-Line? _____

On-Line User Name _____ Password _____

Location of Documents: (safety deposit box, attorney, file,) _____

Number of Box: _____ Name of Financial Institution: _____

Final Arrangement Information

My Final Arrangement Wishes (circle one)

Do you want a: Funeral Memorial Service (body not present)

Do you want to be : Buried Entombed Cremated

If Burial what type of Casket : Wood Metal Bronze Other _____

Do you have a Funeral Home chosen? _____ Name of Funeral Home? _____

Do you have a Pre-Planned Funeral? _____ Location of Documents? _____

Are Funeral Arrangements Pre-Paid? _____ Location of Documents? _____

Contact Information: _____ Phone #: _____

Do you want a viewing? _____ Casket: Open Closed

Are you eligible for Military Services? _____ If so do you want to use them? _____

Head Stone Ordered? _____

Maximum amount to spend on entire Funeral/Service/Burial: _____

Do you have a preferred Cemetery? _____ If so where? _____

Contact Information: _____ Phone #: _____

Do you want a Graveside Service? _____ If so who to Officiate? _____

If Entombed do you have a place reserved? _____

If Cremation do you want to have your ashes scattered? _____

If so where? _____

Please list all additional instructions: (music, flowers, your wishes for your service)
