KRASA LAW
LegalVault Client Enrollment Form

CLIENT CONTACT INFORMATION				
First Name	**Last Name**	**Email Address**		
Mailing Address	**City, State & Zip**			
Date of Birth		**Home Telephone**	**Alt Telephone**	

PHYSICIAN INFORMATION			
Physician Name	**Physician Practice Name**	**Office Telephone**	**Office Fax**
Physician Office Address	**City, State & Zip**		

EMERGENCY CONTACTS					
First Name	**Last Name**	**Relationship**	**Home Tel**	**Work Telephone**	**Mobile Telephone**

ALLERGY INFORMATION

☐ Penicillin ☐ Bee Stings ☐ Shellfish ☐ Sulfa ☐ Latex ☐ Nuts ☐ _____ ☐ _____ ☐ _____ ☐ _____

MEDICAL CONDITIONS

☐ Alzheimer's ☐ Arthritis ☐ Asthma ☐ Cancer ☐ Cancer survivor ☐ Diabetes ☐ Hearing loss ☐ High blood pressure

☐ Heart disease ☐ Low vision ☐ Lung disease ☐ Stroke history ☐ _____ ☐ _____ ☐ _____

MEDICATIONS

☐ _____ Dosage & Frequency: _____ ☐ _____ Dosage & Frequency: _____

☐ _____ Dosage & Frequency: _____ ☐ _____ Dosage & Frequency: _____

CARD NOTE *(Ex: "Pets at home"; limited to 30 characters, use one letter per space)*

Firm Issued By: KRASA LAW

Client Certification: I request that LegalVault™ electronically store my legal healthcare documents and other healthcare information and to make such information available to my healthcare providers. I am aware that my legal healthcare documents and healthcare information are going to be made available to anyone who has access to my security access code and I will not hold LegalVault or my sponsoring law firm responsible for any unauthorized access. I certify that the information supplied to LegalVault by me on this form is correct and that the stored documents are my current legal healthcare documents and information. I agree to immediately notify LegalVault in writing or by logging on their secure website in the event I revoke or modify any of my legal healthcare documents or healthcare information or to convey my desire to terminate this service. I will indemnify and hold harmless LegalVault and my sponsoring law firm for any damages resulting from their reliance on these certifications or on any inaccurate information I supply or for any unauthorized use of this service. By providing a fax number for my physician, I am granting LegalVault and my sponsoring law firm permission to provide an enrollment notification fax to my physician, enabling such physician to obtain my legal healthcare documents and healthcare information. I understand that I am enrolling in this service for convenience of access and not relying on LegalVault or m sponsoring law firm for the exclusive storage of my documents and information.

Signature: _____ Date: _____