

**Complete this form and put it on your refrigerator in a sealed envelope.
Clearly mark it as "File of Life".**

FILE OF LIFE

Name		Date	
Address		DOB	Age

Medical Conditions	Medications	Dosage

Physicians

Doctor		Phone	
Doctor		Phone	
Doctor		Phone	

Recent Hospitalizations or Surgeries

Reason		Date	
Reason		Date	
Reason		Date	

Medical Insurance

Medicare Number	MaineCare Number
Company	Policy Number
Company	Policy Number

Emergency Contacts

Name	Address
Phone 1	Phone 2
Name	Address
Phone 1	Phone 2
Name	Address
Phone 1	Phone 2