Health Information Sheet for Patient Advocate(s)

Name_____Date of Birth_____

Primary Physician_____
Name Telephone

_____
Office location Associated with which hospital?

Specialist:_____
Name Telephone

_____
Office location

Other _____
Name Telephone

_____
Office location

Dentist _____
Name Telephone

_____
Office location

Pharmacist_____
Company Name Telephone

_____
location used for pickup/delivery (?)

Known Medical Conditions_____

_____

_____

Medication(s): After each medication identify what it is for: _____

_____

_____

Blood Type? _____

Date Completed _____

FUNERAL AND BURIAL INSTRUCTIONS

Full Name: _____ Place of Birth: _____
Date of Birth: _____
Present Address: _____ Since: _____

FAMILY INFORMATION

Father's Name: _____ Birthplace: _____
Address if Living _____
Deceased? _____ Date of Death _____
Mother's Maiden Name: _____ Birthplace: _____
Address if Living: _____
Deceased? _____ Date of Death _____

Your Education: School(s) Degree(s) Year

_____
_____

Married _____ Deceased? _____
Spouse or Significant Other's Name/ maiden name
Date of Marriage _____ at _____

Living Children: (please attach another sheet if needed)
Name Date of Birth Address Occupation

_____
_____
Living Grandchildren: (please attach another sheet if needed)
Name Date of Birth Address Occupation

_____
_____
Living Brothers and Sisters: (please attach another sheet if needed)
Name Date of Birth Address Occupation

_____
_____

Deceased Children, Grandchildren, Brothers and Sisters:
Name Relationship Date of Death

_____
_____
Other Relatives: (please attach another sheet with names, addresses and relationship)

COMMUNITY INFORMATION

Church: _____

Clubs, Fraternal and Military Organizations: _____

Civic Organizations: _____

Offices held and recognition received: _____

Military Service	Rank Attained	Unit	Date Entered	Date Discharged

Employment/Business/Corporate Directorates and Offices Held:

Firm	Since (date)	Present Position

Other items of interest concerning business or history: _____

_____

_____

BURIAL ARRANGEMENTS

I prefer:

☐ BURIAL

☐ Cemetery Lot

- ☐ Need to purchase
- ☐ Already own
  - Where? _____
  - Lot #? _____
- ☐ Mausoleum
  - Which? _____
  - Where? _____

☐ CREMATION

Wishes for my ashes:

Burial (Where?) _____

Scattered (Where and by whom?) _____

Other _____

FUNERAL HOME

Name: _____

Address: _____ Phone: _____

OTHER PREFERENCES

Do you wish a vault? _____What kind of Casket?_____

Any jewelry, clothing or other items you wish to be buried with or not buried with?

_____

_____

FUNERAL ARRANGEMENTS

I wish: Calling hours:

☐	No funeral service	☐	Church: _____	☐ at funeral home
☐	Memorial service	☐	Home: _____	☐ at my home
☐	Funeral service:	☐	Mortuary:_____	☐ no calling hours
	If funeral, from:		Chapel: _____	

SERVICES

Clergyman/Rabbi:_____

Special Bible readings, Special Music or other readings: (please attach information)

Flowers?_____Donation to organization in lieu of flowers?_____

Which organization? _____

Requested pallbearers or club, fraternal, civic or military organizations you wish to assist with your service?

_____ _____

_____ _____

_____ _____

Preferences for stone or marker?_____

Any special inscription or epitaph? (Please attach)

Cemetery_____

Obituaries - preference for printing in following papers:_____

_____

Date Completed: _____

This is merely informational. If you wish to make your organ donation binding on your family, it is also important to remember that you complete the organ donor form with the Secretary of State or contact "The Gift of Life" organization in Ann Arbor at 800-482-4881 (www.giftoflifemichigan.org).

Anatomical Gift Form

I, _____, hereby make this anatomical gift, if medically acceptable, to take effect upon my death.

Personal Information
Home Address: _____

Social Security Number: _____

Patient Advocate Name: _____

Patient Advocate Telephone Number: _____

I give (place a check mark in the appropriate box):
☐ Any needed organs or parts
☐ Only the following organs or parts:
_____

I have previously signed with a medical school: ☐ Yes ☐ No

If yes, name of school: _____

I have filed written instruction with the Secretary of State or Gift of Life: ☐ Yes ☐ No

I have the following special wishes concerning my anatomical gift:_____
_____
_____

I authorize the physician listed below to furnish my attending physician with any pertinent medical information in the event of my death:
Physician's name: _____

Physician's Telephone Number: _____

I have signed my anatomical gift form on _____.

Donor Signature: _____

Relatives and Close Friends to Be Contacted

Name _____
Relationship _____ Phone _____

Name _____
Relationship _____ Phone _____

Name _____
Relationship _____ Phone _____

Name _____
Relationship _____ Phone _____

Name _____
Relationship _____ Phone _____

Name _____
Relationship _____ Phone _____

Name _____
Relationship _____ Phone _____

Name _____
Relationship _____ Phone _____

Name _____
Relationship _____ Phone _____

Name _____
Relationship _____ Phone _____

Name _____
Relationship _____ Phone _____

Date Completed: _____

Location Lists & Contacts and Directions for Trustee

In this section there are several schedules for you to complete and information for the successor Trustee.

Location of Important Papers

Step 1: Identify two locations where important documents are stored.

LOCATION #1: _____

LOCATION #2: _____

Step 2: Indicate (with a check mark) where each of the following can be found:

TYPE OF DOCUMENTS	DOCUMENT	#1	#2
ESTATE PLANNING DOCUMENTS	Living Trust		
	Trust Property Inventory		
	Pour Over Will		
	Certificate of Trust Existence and Authority		
	Estate Planning Letter		
	Living Will and Patient Advocate Designation		
	Anatomical Gift Form		
	Durable Power of Attorney		
BUSINESS PAPERS	Partnership Agreements		
	Corporation Papers		
	Employment Agreements		
TAX RECORDS	State and Federal Income Tax Returns		
	Gift Tax Returns		
	Estate Tax Returns		
BANKING RECORDS	Checkbooks		
	Passbooks		
	Certificates of Deposit		
	Bank Statements and Canceled Checks		
	Credit Card Records		

UPDATED ESTATE PLANNING INFORMATION

Please use this form to update the Confidential Estate Planning Information that you completed when we set up your Estate Plan. A copy of that information should be located in this section of your notebook.

Date Completed:_____

Advisors. List names, addresses and phone numbers.

Financial Advisor:_____

Life insurance agent: _____

Real Estate Interests.
Please list all real property that you own, including Time Shares, land contract sales or purchases or Oil and Gas Interests for which you have a deed.

_____ _____
_____ _____

Checking/Savings/Money Market Accounts/Certificate of Deposit (CD)

NAME OF INSTITUTION	ACCOUNT NUMBER
_____	_____
_____	_____

Investment/Brokerage Accounts. (Stocks, bonds, dividend reinvestment account)
Please list all accounts with brokerage firms that hold stock certificates, bonds and mutual funds for you.

NAME OF BROKERAGE	ACCOUNT NUMBER
_____	_____
_____	_____
_____	_____

Retirement Benefits. (IRA, 401k, 403B, Annuity)

COMPANY NAME	ACCOUNT NUMBER
_____	_____
_____	_____
_____	_____
_____	_____

Life Insurance:

Company: _____ Company: _____

Policy Number: _____ Policy Number: _____

Insured: _____ Insured: _____

Owner: _____ Owner: _____

TYPE OF DOCUMENTS	DOCUMENT	#1	#2
REAL ESTATE RECORDS	Real Estate Deeds		
	Title Insurance Policies		
	Notes and Loan Contracts		
	Rental Property Records		
INVESTMENT RECORDS	Stock and Bond Certificates		
	Brokerage Account Records		
	Annuity Contracts		
	Limited Partnership Agreements		
TITLE TO PERSONAL PROPERTY	Automobile Title		
	Boat Title		
	Other Personal Property		
	Other Personal Property		
PERSONAL PAPERS	Marriage Certificate		
	Birth Certificates		
	Military Records		
	Citizenship Papers		
	Divorce Judgments		
	Life Insurance Policies		
	Other		
	Other		

Date Completed: _____

ACCOUNT PASSWORD INFORMATION

ACCOUNT	*PASSWORD INFORMATION*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

UPDATED ESTATE PLANNING INFORMATION

Please use this form to update the Confidential Estate Planning Information that you completed when we set up your Estate Plan. A copy of that information should be located in this section of your notebook.

Date Completed:_____

Advisors. List names, addresses and phone numbers.

Financial Advisor:_____

Life insurance agent: _____

Real Estate Interests.
Please list all real property that you own, including Time Shares, land contract sales or purchases or Oil and Gas Interests for which you have a deed.

_____ _____
_____ _____

Checking/Savings/Money Market Accounts/Certificate of Deposit (CD)

NAME OF INSTITUTION	ACCOUNT NUMBER
_____	_____
_____	_____

Investment/Brokerage Accounts. (Stocks, bonds, dividend reinvestment account)
Please list all accounts with brokerage firms that hold stock certificates, bonds and mutual funds for you.

NAME OF BROKERAGE	ACCOUNT NUMBER
_____	_____
_____	_____
_____	_____

Retirement Benefits. (IRA, 401k, 403B, Annuity)

COMPANY NAME	ACCOUNT NUMBER
_____	_____
_____	_____
_____	_____
_____	_____

Life Insurance:

Company: _____ Company: _____

Policy Number: _____ Policy Number: _____

Insured: _____ Insured: _____

Owner: _____ Owner: _____

TYPE OF DOCUMENTS	DOCUMENT	#1	#2
REAL ESTATE RECORDS	Real Estate Deeds		
	Title Insurance Policies		
	Notes and Loan Contracts		
	Rental Property Records		
INVESTMENT RECORDS	Stock and Bond Certificates		
	Brokerage Account Records		
	Annuity Contracts		
	Limited Partnership Agreements		
TITLE TO PERSONAL PROPERTY	Automobile Title		
	Boat Title		
	Other Personal Property		
	Other Personal Property		
PERSONAL PAPERS	Marriage Certificate		
	Birth Certificates		
	Military Records		
	Citizenship Papers		
	Divorce Judgments		
	Life Insurance Policies		
	Other		
	Other		

Date Completed: _____

ACCOUNT PASSWORD INFORMATION

ACCOUNT	*PASSWORD INFORMATION*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Key Advisors to Be Contacted

Attorney _____

Phone _____ Firm _____

Address _____

Accountant _____

Phone _____ Firm _____

Address _____

Auto Insurance Agent _____

Phone _____ Firm _____

Address _____

Bank _____

Phone _____ Bank _____

Address _____

Credit Union _____

Phone _____ Bank _____

Address _____

Clergy _____

Phone _____ Church/Synagogue _____

Address _____

Doctor _____

Phone _____ Hospital _____

Address _____

Employer _____

Phone _____ Firm _____

Address _____

Financial Advisor _____

Phone _____ Firm _____

Address _____

Funeral Director _____

Phone _____ Firm _____

Address _____

General Insurance Agent _____

Phone _____ Firm _____

Address _____

Mortgage Company _____

Phone _____ Firm _____

Address _____

Life Insurance Agent _____

Phone _____ Firm _____

Address _____

Business Partner _____

Phone _____ Firm _____

Address _____

Trust Officer _____

Phone _____ Institution _____

Address _____

Other _____

Phone _____ Firm _____

Address _____

*** (Use this provision to renew this Durable Power of Attorney if no other changes are required and the date of your power of attorney is over five years old.)*

I, _____, reconfirm the validity of this Durable Power of Attorney on _____.

_____

*** (Use this provision to renew this Durable Power of Attorney if no other changes are required and the date of your power of attorney is over five years old.)*

I, _____, reconfirm the validity of this Durable Power of Attorney on _____.

_____

*** (Use this provision to renew this Durable Power of Attorney if no other changes are required and the date of your power of attorney is over five years old.)*

I, _____, reconfirm the validity of this Durable Power of Attorney on _____.

_____

*** (Use this provision to renew this Durable Power of Attorney if no other changes are required and the date of your power of attorney is over five years old.)*

I, _____, reconfirm the validity of this Durable Power of Attorney on _____.

_____

SPECIFIC GIFTS UPON DEATH

Pursuant to the provisions of my estate plan which incorporates this specific gifts form by reference, I instruct the distribution of the following gifts:

Description of Gift: __________
Desired Recipient and Relationship: __________
Dated: __________ Signed: __________

Description of Gift: __________
Desired Recipient and Relationship: __________
Dated: __________ Signed: __________

Description of Gift: __________
Desired Recipient and Relationship: __________
Dated: __________ Signed: __________

Description of Gift: __________
Desired Recipient and Relationship: __________
Dated: __________ Signed: __________

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Desired Recipient and Relationship: __________
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Desired Recipient and Relationship: __________
Dated: __________ Signed: __________

Description of Gift: __________
Desired Recipient and Relationship: __________
Dated: __________ Signed: __________

Description of Gift: __________
Desired Recipient and Relationship: __________
Dated: __________ Signed: __________

Description of Gift: __________
Desired Recipient and Relationship: __________
Dated: __________ Signed: __________

This list must be handwritten, signed and dated where indicated.

Minor Child Information Sheet

Date Completed _____

Child's
Name_____
(First) (Middle) (Last)

Nick Name _____ Date of Birth_____

Pediatrician_____
Name Address Telephone

Dentist _____
Name Address Telephone

Other _____
Name Address Telephone

Other _____
Name Address Telephone

Known Medical
Conditions_____

_____

Medication(s) and Location:_____

_____

Babysitter

_____
Name Address Telephone Age

_____
School/Day Care Teacher/Provider Address Telephone

Diet (Restrictions,
Likes/Dislikes)_____

_____

Lessons/Sport(s)_____

Interest(s)_____

Date Completed: _____

My Agent under any Durable Power of Attorney or my Trustee under my Living Trust shall take possession of any and all pets I own. They shall have the authority to arrange for them to receive medical treatment as deemed appropriate and to pay for all such services from my resources.

Instructions for Pet

Description of Pet

Pet's Name: _____

Approximate Age of Pet_____ Breed_____

New Owner

I request my pet be given to the following individual(s)(in order of preference):

1. _____
Address _____ Ph. _____

2. _____
Address _____ Ph. _____

Medical Information

Veterinarian _____ Ph. _____

Address _____

Medical Problems/Allergies: _____ Medication(s): _____

Food
Type/Amount/Frequency:_____

Miscellaneous
Favorite Treats, Toys, Games:_____

Groomer _____ Address _____ Ph. _____

Boarding Kennel _____ Address _____ Ph._____

Exercise Routine:_____

Other Instructions:_____
_____
_____
_____

Date Completed: _____