

MEDICAL ALERT CUSTOMER FORM

Once completed, FAX to:
310-392-0548
(please print neatly)

GENERAL INFORMATION

CUSTOMER NAME _____

ADDRESS _____

NEAREST CROSS STREET _____

CITY _____

STATE _____

ZIP _____

PRIMARY PHONE NUMBER _____

SECONDARY PHONE NUMBER _____

ACCESS TO RESIDENCE: Describe how paramedics can gain access.
 Include location of any hidden keys, lock box or gate codes, etc.

DEALERS: COMPLETE THIS BOX

ACCOUNT # (must be 6 digits, including line #) _____

DATE _____

DEALER NUMBER _____

SYSTEM BRAND & MODEL # (if not from ATW) _____

REPORTING FORMAT (if not from ATW)

DAILY TEST SIGNAL *additional charges apply

WEEKLY TEST SIGNAL

CALL LIST

<u>NAME</u> List the order that responsible people are to be called	<u>PHONE NUMBER</u> Please include area code	<u>TYPE</u> home, cell, etc.	<u>RELATION TO OWNER</u> (neighbor, relative, friend, etc.)	<u>KEY</u> to home?
PARAMEDICS DISPATCH NUMBER: (Please list if you have this number)				

ESSENTIAL MEDICAL INFORMATION

DATE OF BIRTH: _____ BLOOD TYPE: _____ PREFERRED HOSPITAL: _____

PHYSICIAN & 24-HOUR PHONE NUMBER: _____

ALLERGIES: _____

MEDICATIONS TAKEN: _____

OTHER ESSENTIAL CONDITIONS, INCLUDING MAJOR SURGERIES: _____

CUSTOMER PAYMENT AUTHORIZATION FORM

Customer Name: _____ Date: _____

Alarm Account #: _____ Dealer #: _____

Billing Name: _____
(if different than Customer_)

Billing Address: _____
(if different than alarm location)

Monthly Amount: _____ Billed: Monthly Quarterly Annually

Advance Payment Received *(if any)*: _____ Billing Starts: _____
(unless otherwise specified, billing will start on the first of the month following the installation date)

Method of Payment (check one):

Mailed Statement

Electronic Deduction from Credit Card

Visa MasterCard Discover American Express

Account #: _____

Expiration Date: _____

Security Code on Back of Card: _____

Electronic Funds Transfer (EFT) from Checking Account **

**** Must include copy of a voided check**

Bank: _____

Account #: _____

Routing #: _____

Electronic Funds Transfer (EFT) from Savings Account

Bank: _____

Account #: _____

Routing #: _____

Customer Signature

By signature above authorizes MONITORING SERVICES to make EFTs from my bank account, or charge my credit card account, in the amount specified above as my Payment for monitoring services.