

RESIDENT INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Social Security Number: _____

Marital Status: Single Married Divorced Widowed Gender: M F

Race (*check one*):

_____ White/Caucasian _____ Black/African American _____ Hispanic/Latino

_____ Native American _____ Asian _____ Pacific Islander _____

Veteran? Y N Military Branch: _____

Billing Statement

Billing statements are to go to:

Name _____ Address _____

Statement Delivery Preference: Email: _____ Regular Mail (see address above)**Emergency Contact #1**

Name: _____ Relationship: _____

Primary Phone #: _____ Alternate Phone #: _____

Address: _____

Street City State Zip

Email: _____ Primary Contact? Y N

Emergency Contact #2

Primary Contact? Y N

Name: _____ Relationship: _____

Primary Phone #: _____ Alternate Phone #: _____

Address: _____

Street City State Zip

Email: _____ Primary Contact? Y N

Financial Power of Attorney

Primary Contact? Y N

Name: _____ Relationship: _____

Primary Tel. #: _____ Alternate Tel. #: _____

Address: _____

Street

City

State

Zip

Email: _____

Responsible Party

Name: _____ Relationship: _____

Primary Phone #: _____ Alternate Phone #: _____

Address: _____

Street

City

State

Zip

Email: _____ Primary Contact? Y N

Guarantor/Responsible Party

Name: _____ Relationship: _____

Primary Tel. #: _____ Alternate Tel. #: _____

Address: _____

Street

City

State

Zip

Email: _____ Primary Contact? Y N

Health Care Power of Attorney **Durable?** (Check if "Yes")

Name: _____ Relationship: _____

Primary Tel. #: _____ Alternate Tel. #: _____

Address: _____

Street

City

State

Zip

Email: _____ Primary Contact? Y N

Guardian **Court-appointed?** (Check if "Yes")

Name: _____ Relationship: _____

Primary Tel. #: _____ Alternate Tel. #: _____

Address: _____

Street

City

State

Zip

Email: _____ Primary Contact? Y N

Emergency Treatment Preferences

Check all that apply:

Advance Directive/Living Will Yes No POLST Yes No DNRO Yes No

(Please attach document(s) if applicable)

Health/Medical Insurance

Primary Insurance: _____

Policy #: _____ Grp#: _____

Secondary Insurance: _____

Policy #: _____ Grp#: _____

Primary Physician Name: _____ Tel. # _____

Address: _____

Street City State Zip

Dentist Name: _____ Tel. # _____

Address: _____

Street City State Zip

Eye Doctor Name: _____ Tel. # _____

Address: _____

Street City State Zip

Podiatrist Name: _____ Tel. # _____

Address: _____

Street City State Zip

Psychiatrist Name: _____ Tel. # _____

Address: _____

Street City State Zip

Hospital Preference: _____

Funeral Home Preference: _____

