RESIDENT DATA

Last **First** **Middle**	**Apt. #** **Move In Date**:
Date of Birth:_____/_____/_____ **Sex:** ☐ **Male** ☐ **Female** **Marital Status:** ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** Previous Address:	**Social Security No.** _____ **Phone:** (_____) _____ Religion/Church Affiliation _____ **Veteran Status** _____ **Number**_____

EMERGENCY CONTACTS

Primary:	**Secondary:**
Name: _____	Name: _____
Address: _____	Address: _____
Phone No.: (____) _____	Phone No.: (____) _____
Relationship: _____	Relationship: _____

SERVICE PROVIDERS (**MUST** have addresses and telephone number to be considered complete)

TYPE OF SERVICE	NAME AND ADDRESS	TELEPHONE NUMBER
Primary Physician		
Preferred Hospital		
Specialists		
Home Care Provider		
Pharmacy		
Preferred Nursing Home		
Preferred Funeral Home		
Other		

Primary Medical Insurance _____ **ID #** _____**Group#**_____

Secondary Medical Insurance_____ **ID#**_____ **Group#**_____

Resident Has: ☐ **Living Will** ☐ **Medical Durable Power of Attorney** ☐ **Do Not Resuscitate**
Copies of above checked documents on file: ☐ **Yes** ☐ **No** **Information on these documents has been offered upon admission.**

Date of last TB (Required)		
Flu Vaccination		
Pneumonia Vaccination		