RESIDENT INFORMATION SHEET

ADULT CARE HOME INFORMATION:

Operator Name:	Operator Phone Number:	Address:

PERSONAL INFORMATION:

Resident Name:		Original Admission Date:	Date Recently Updated:
Social Security #		Medicare #	
Medicaid #	VA#	Other Insurance:	
Policy #			
Birth Date:	Birthplace:		Sex: ☐Male ☐Female
Hobbies/Interests:		Preferred Hospital:	
Favorite Activities:		Case Manager & Telephone:	
Food Likes/Dislikes:		Preferred Funeral Home Name and Telephone:	
Other(please specify)		Faith/Worship affiliation:	

GENERAL INFORMATION:

Prior living situation: ☐ Living Alone ☐Family Member ☐A ssisted Living ☐Foster Home ☐Nursing Home ☐ Hospital ☐ Other (please explain)	
Primary Physician's Name & Telephone:	Nurse's Name & Telephone:
Other Physician's Name and Telephone:	Other Health Professional's Name & Telephone:
Other Physician's Name and Telephone:	Dentist's Name & Telephone:
Other Physician's Name and Telephone:	Pharmacy Name & Telephone:
Power of Attorney & Telephone:	Legal Guardian
Legal Representative:	**Relationship:**
Address (City, State, & Zip)	**Telephone:**
Relative:	**Relationship:**
Address (City, State, & Zip)	**Telephone:**
Relative:	**Relationship:**
Address (City, State, & Zip)	**Telephone:**
Other Emergency Contacts	

MEDICAL INFORMATION:

(Please check all that apply) ☐ DNR ☐ Physician Directive ☐ POLST ☐ Advanced Directives ☐Other:	Date:
Diagnosis: (Please update when changed)	
Home Health Agency:	
Allergies:	