At Home Senior Living Residence Application

Resident Name_____ **Apt. #**_____

Race:_____ **Sex:**_____ **Marital Status:**_____ **Religious Preference:**_____

Previous Address:_____

Birthplace: _____ **Birth Date:** _____ **SS#:** _____

Veteran? #_____ **Branch of Service:**_____ **Pet?**_____

INSURANCE INFORMATION

Medicare A:_____ **Medicare B:**_____

Supplemental Insurance Company:_____

Supplemental Insurance ID#_____ **Rx Benefit?**_____

HEALTH HISTORY

Diagnosis_____

Allergies/Reactions:_____ **Diet:**_____

Special Devices:_____

Does Resident have a POA for Financial?_____ **Medical?**_____ **Guardianship?**_____

Primary Physician:_____

Address:_____

Phone:_____ **Fax:**_____

Secondary Physician(s) _____

Address:_____

Phone:_____ **Fax:**_____

Secondary Physician(s) _____

Address:_____

Phone:_____ **Fax:**_____

Hospital Preference: _____

Address: _____

Phone: _____ **Fax:** _____

Church Name: _____ **Pastor:** _____

Address: _____

Phone: _____ **Fax:** _____

Pharmacy Preference: _____

Address: _____

Phone: _____ **Fax:** _____

Dentist: _____

Address: _____

Phone: _____ **Fax:** _____

Optometrist: _____

Address: _____

Phone: _____ **Fax:** _____

Home Health Preference: _____

Address: _____

Phone: _____ **Fax:** _____

Hospice Preference: _____

Address: _____

Phone: _____ **Fax:** _____

Funeral Home: _____

Address: _____

Phone: _____ **Fax:** _____

Medication List

Medication Name	Dosage	Directions

List Updated on: _____

Do You have an Advanced Directive? _____ **Type:**_____

Note: This information is confidential and to be used for emergency purposes only.