Living Well
ADULT DAY CARE

Office: (401) 722-1311 **FAX:** (401) 722-2246 **Email:** www.livingwelladultdaycareri.com

Admission Application

Name	***Date of Birth*** ***M F Sex***
Address	***Social Security Number***
City, State, Zip Code	***Case Manager Name***
Home Phone ***Cell Phone***	***Work Phone*** ***Cell Phone***
	Email

Alternative Emergency Contacts

Primary Emergency Contact	*Secondary Emergency Contact*
Home Phone *Work Phone*	*Home Phone* *Work Phone*

Medical Information

List all Diagnosis (Medical and Psychiatric)

Physician's Name *Phone Number*

Psychiatrists *Phone Number*

Allergies: Food/Medication

Background Criminal Information

Have you been convicted of any misdemeanors or felony(s) Please circle: YES NO

If yes please list:

Interest and Hobbies

List Hobbies and Interest

Release for Medical and/or Psychological Information

I authorize Living Well Adult Day Care to obtain patient medical information such as physical exams and psychiatric evaluations from the above physicians. This information may be faxed. These documents will be necessary for my involvement in the Living Well Adult Day Program.

Participant Signature ***Date***

(I attest that all information above is accurate and correct. I understand if I provide willingly inaccurate information this may jeopardize my enrollment To Living Well Adult Day Care).

Witness Signature ***Date***