|  |  |  |
| --- | --- | --- |
| **RESIDENT NAME:**  | **DOB:** | **AGE:** |
| **ADMIT DATE:** | **GENDER: [ ]  Female** **[ ]  Male**  |
| **PREVIOUS LIVING SITUATION:**  | **PRIMARY LANGUAGE:**  |
| **CODE STATUS: [ ]  Full Code/CPR [ ]  DNR/NO CPR [ ]  Unknown [ ]  Other:** |
| **ALLERGIES:** |
| **DIAGNOSES:**  |
| **MARTIAL STATUS:** | **SPOUSE’S NAME:** |
|  |
| **PRIMARY CONTACT:** | **RELATIONSHIP:**  |
| **[ ]  POA/DPOA of Healthcare [ ]  POA/DPOA of Finances [ ]  Guardian [ ]  Family Member [ ]  Other:** |
| **PHONE NUMBER:** | **ADDRESS:**  |
| **SECONDARY CONTACT:** | **RELATIONSHIP:**  |
| **[ ]  POA/DPOA of Healthcare [ ]  POA/DPOA of Finances [ ]  Guardian [ ]  Family Member [ ]  Other:** |
| **PHONE NUMBER:** | **ADDRESS:**  |
|  |
| **HEALTH INSURANCE:**  | **GROUP #:** |  |
| **MEDICARE #:** |  |
|  |
| **PRIMARY CARE PHYSICIAN:** | **PHONE NUMBER:**  |
| **ADDRESS:**  | **FAX:**  |
| **OTHER PHYSICIAN:** | **PHONE NUMBER:**  |
| **ADDRESS:**  | **FAX:**  |
| **DENTIST:**  | **PHONE NUMBER:**  |
| **ADDRESS:**  | **FAX:**  |
| **PHARMACY:**  | **PHONE NUMBER:**  |
| **ADDRESS:**  | **FAX:**  |
| **PREFERRED HOSPITAL:**  | **PHONE NUMBER:**  |
| **ADDRESS:**  | **FAX:**  |
| **FUNERAL ARRANGEMENTS:**  | **PHONE NUMBER:**  |
| **ADDRESS:**  | **FAX:**  |