|  |  |  |  |
| --- | --- | --- | --- |
| **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:** | | |