AFFECTIONATE CARE HOMES

Where care meets comfort.

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Assisted Living Admission

Applicant Name: ______________________________ Date: ____________

Projected Admission Date: ____________ Contact Person: ____________

Relationship: ____________ Phone: ____________

Email: ____________ Address: ____________

SSN: ____________ Driver's License No. ____________

DOB: ____________ Age: ____________ Sex: ____________

Marital Status: ____________ Spouse's Name: ____________

Gender: ________ Occupation: ____________ Phone: ____________

Insured Party: ____________ Relationship to Patient: ____________

Insurance Company: ____________ Phone No. ____________

Address: ______________________________

Policy No. ____________ Group No. ____________

Medicare No. ____________ 2nd Insurance No. ____________

Current Living Situation: ❑ Assisted Living ❑ Private Residence ❑ Nursing Facility ❑ Acute Care

Advance Directives: ❑ Do Not Resuscitate ❑ Living Will ❑ Other: ____________

1st Language: ____________ Religious/Church Affiliation: ____________

Physician: ____________ Phone No. ____________

Address: ______________________________

Dentist: ____________ Phone No. ____________

Address: ______________________________

Illnesses: ______________________________

____

Injuries: ______________________________

____

Allergies: ______________________________

____

Medications: ______________________________

____

______________________________ ____________

Signature Date