

RESIDENT PROFILE

RESIDENT: _____ CASE #: _____ GROUP HOME: _____

DOB: _____ DOA: _____ SOCIAL SECURITY #: _____

GUARDIAN: _____ PHONE (H): _____ (W): _____

If the resident has a guardian staff must comply with guardianship procedures listed on the back of this form.

ADDRESS: _____ ZIP: _____ DATE APP: _____

RELATIVE #1: _____ PHONE (H): _____ (W): _____

ADDRESS: _____ ZIP: _____

RELATIVE #2: _____ PHONE (H): _____ (W): _____

ADDRESS: _____ ZIP: _____

PERSONS PERMITTED TO REMOVE RESIDENT FROM FACILITY: _____

MEDICAL

DIAGNOSIS: _____

DATE OF TESTING: _____

MEDICAL ALERTS:

() SEIZURE ; () HEP. B; () ALLERGY TO:

PRIMARY PHYSICIAN: _____ PHONE: _____

ADDRESS: _____ ZIP: _____

PHYSICIAN #2: _____ SPECIALTY: _____ PHONE: _____

PHYSICIAN #3: _____ SPECIALTY: _____ PHONE: _____

DENTIST: _____ ADDRESS: _____ PHONE: _____

MEDICAID #: _____ MEDICARE #: _____

PRIVATE INS. POLICY #: _____ CARRIER: _____

POLICY HOLDER: _____ BILLING INFO: _____

FINANCIAL

SSA () ACCT #: _____ FUNDS MANAGED BY: _____

SSI () SA () OTHER RESOURCES: _____

EMPLOYER: _____ PHONE: _____ CONTACT PERSON: _____

MISCELLANEOUS INFORMATION: