The Gardens at Calvary

PERSONAL CARE HOME

RESIDENT EMERGENCY INFORMATION FORM

RESIDENT INFORMATION

Resident: _____ Community: The Gardens at Calvary

Age: _____ Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married

Date of Birth: ____ / ____ / ____ ☐ Widowed ☐ Divorced
Month Day Year

Veteran?

Social Security Number: ____ - ____ - ____ ☐ Yes ☐ No Move In Date Apartment

Last Phone Number: (____) ____ - ____ ____ / ____ / ____ ____
Month Day Year

Last Address: _____ Religion / Church Affiliation
Street

_____ ____ _____ _____
City State Zip Code Please Give Name of Place of Worship

EMERGENCY CONTACT INFORMATION

1 Name: _____
Street: _____
City: _____ St: ____ Zip: _____
Home / Cell Phone (____) ____ - _____
Work Phone (____) ____ - _____
E-mail:

2 Name: _____
Street: _____
City: _____ St: ____ Zip: _____
Home / Cell Phone (____) ____ - _____
Work Phone (____) ____ - _____
E-mail:

3 Name: _____
Street: _____
City: _____ St: ____ Zip: _____
Home / Cell Phone (____) ____ - _____
Work Phone (____) ____ - _____
E-mail:

4 Name: _____
Street: _____
City: _____ St: ____ Zip: _____
Home / Cell Phone (____) ____ - _____
Work Phone (____) ____ - _____
E-mail:

Name of Responsible Party (Guardian)

Name of Payee (Financial Representative)

SERVICE PROVIDERS AND INSURANCE INFORMATION

TYPE OF SERVICE	NAME AND ADDRESS OF SERVICE PROVIDER	PROVIDER PHONE
Primary Physician		( ) -
		FAX ( ) -
Dentist		( ) -
		FAX ( ) -
Specialist(s)		( ) -
		FAX ( ) -
Therapy Provider(s)		( ) -
		FAX ( ) -
Hospital of Choice		( ) -
		FAX ( ) -
Mortuary		( ) -

Medical Insurance Company: Name: Policy Number:

Phone ( ) -

Street

City State Zip

Medicare Number

Resident Has: ☐ Living Will ☐ Do Not Resuscitate Copies on File ?

☐ Power of Attorney ☐ Medical Durable Power of Attorney ☐ Yes

Allergies: