

# The Gardens at Calvary

## ASSISTED LIVING COMMUNITY RESIDENT EMERGENCY INFORMATION FORM

### RESIDENT INFORMATION

Resident: _____		Community: <u>The Gardens at Calvary</u>	
Age: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
Date of Birth: _____ / _____ / _____ <small>Month Day Year</small>			
Social Security Number: _____ - _____ - _____		Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Last Phone Number: (____) _____ - _____		Move In Date: _____ / _____ / _____ <small>Month Day Year</small>	
Last Address: _____ <small>Street</small>		Religion / Church Affiliation _____	
_____	_____	_____	_____
<small>City</small>	<small>State</small>	<small>Zip Code</small>	<small>Please Give Name of Place of Worship</small>

### EMERGENCY CONTACT INFORMATION

<p>1 Name: _____</p> <p>Street: _____</p> <p>City: _____ St: _____ Zip: _____</p> <p>Home / Cell Phone _____ Work Phone _____</p> <p>(____) _____ - _____ (____) _____ - _____</p> <p>E-mail: _____</p>	<p>2 Name: _____</p> <p>Street: _____</p> <p>City: _____ St: _____ Zip: _____</p> <p>Home / Cell Phone _____ Work Phone _____</p> <p>(____) _____ - _____ (____) _____ - _____</p> <p>E-mail: _____</p>
<p>3 Name: _____</p> <p>Street: _____</p> <p>City: _____ St: _____ Zip: _____</p> <p>Home / Cell Phone _____ Work Phone _____</p> <p>(____) _____ - _____ (____) _____ - _____</p> <p>E-mail: _____</p>	<p>4 Name: _____</p> <p>Street: _____</p> <p>City: _____ St: _____ Zip: _____</p> <p>Home / Cell Phone _____ Work Phone _____</p> <p>(____) _____ - _____ (____) _____ - _____</p> <p>E-mail: _____</p>
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 _____	Medicare Number _____	
(____) _____ - _____	City _____ State _____ Zip _____		

Resident Has:  Living Will  Do Not Resuscitate  Copies on File ?  Allergies: \_\_\_\_\_

Power of Attorney  Medical Durable Power of Attorney  Yes