

Fountain of Youth Adult Care Home, LLC
PRELIMINARY ADMISSION DATA

DATE OF ACCEPTANCE: _____

Full Name: _____ Date of Birth: ____/____/19____

Marital Status: _____ Social Security Number: _____ - _____ - _____

Address Before Admission: _____

Referred by: _____ Medicare Number: _____

Secondary Insurance (Name / number): _____

HOME WILL NEED A COPY OF EACH INSURANCE CARD FOR EMERGENCY PURPOSES.

| PERSON | NAME | ADDRESS | PHONE |
|-------------------------------|------|---------|-------|
| <i>RESIDENT REP</i> | | | |
| <i>PHYSICIAN</i> | | | |
| <i>DENTIST</i> | | | |
| <i>OPTOMETRIST</i> | | | |
| <i>PHARMACY</i> | | | |
| <i>HOME HEALTH AGENCY</i> | | | |
| <i>EMERGENCY CONTACT</i> | | | |
| <i>CLERGY</i> | | | |
| <i>CASE MANAGER</i> | | | |
| <i>MORTUARY</i> | | | |
| | | | |
| | | | |
| | | | |

SPECIAL DIET: _____

FOOD ALLERGIES: _____

FOOD LIKES: _____

FOOD DISLIKES: _____

HOBBIES: _____

SOCIAL ACTIVITY LIKES: _____

RECREATIONAL ACTIVITY LIKES: _____

REHABILITATIVE LIKES: _____

ACTIVITY DISLIKES: _____

MEDICATION ALLERGIES: _____

OTHER INFORMATION: _____

Signature of Person Completing Form Date