New Hope Gracious Personal Care

Resident Application

Personal Information

Full Name: _____ Male/Female

Prefers to be Called: _____

Birthdate ____/____/_____ SS# _____ Race: _____

Primary Language: _____ Living Will: Yes/No (please attach copy)

Desired Room Type: Private/Semi-Private/First Available: Notes: _____

Previous Occupation: _____ Religious Preference: _____

Hobbies/Interests: _____ Referred by: _____

Emergency Contacts

1. _____ Relationship _____ Home (____) ____ -_____

   Address _____ Cell (____) ____ -_____

   City _____ St: ____ Zip: _____ Email: _____

2. _____ Relationship _____ Home (____) ____ -_____

   Address _____ Cell (____) ____ -_____

   City _____ St: ____ Zip: _____ Other (____) ____ -_____

3. _____ Relationship _____ Home (____) ____ -_____

   Address _____ Cell (____) ____ -_____

   City _____ St: ____ Zip: _____ Other (____) ____ -_____

Billing & Insurance Information

Who is responsible for making the monthly payment?: Self or Family Member? _____

Name _____ Relationship _____ Home (____) ____ -_____

Primary Insurance: _____ ID# _____

Secondary Insurance: _____ Group # _____

Secondary Insurance ID #: _____

Medicare HMO OR Medicare + Supplement (Circle One). Please attach copy of cards, front and back.

Physicians

Primary Care: _____ Phone: _____

Dentist: _____ Phone: _____

Specialists: _____

_____

Would you like to use our house physician? _____

Hospital Preference: _____

Allergies: _____

Special Diet: _____

Recent Hospitalizations (date/LOS/Reason) _____

Medications

Medication Name	Dosage	Frequency	Prescriber

Additional Information

_____

_____

_____

_____

_____

_____