HILLCREST NURSING CENTER: PRE-ADMISSON INQUIRY

RESIDENT NAME		DOB		AGE		M ☐ F ☐	
CURRENT ADDRESS							
DATE OF INQUIRY		DATE OF ADMISSION		ROOM NUMBER			
PAYMENT	PRIVATE ☐ PUBLIC AID ☐ APPROVED ☐ PENDING ☐ VA ☐				PRE-SCREENING YES ☐ NO ☐		
SS#		MED#		PA#		REC#	
INCOME $		SS $		PENSION $			
DEPOSIT $		PA PENDING DATE OF FIRST APPOINTMENT			SECOND		
MARITAL STATUS	S ☐ M ☐ W ☐ D ☐	PLACE OF BIRTH		EDUCATION			
INSURANCE							
DIAGNOSIS							

IN CASE OF EMERGENCY PLEASER NOTIFY							
NAME		RELATION		EMAIL			
ADDRESS							
HOME #		WORK #		OTHER #			
NAME		RELATION		EMAIL			
ADDRESS							
HOME #		WORK #		OTHER #			

PHYSICIAN NAME				OFFICE #			
ADDRESS							
HOSPITAL		FUNERAL HOME					

RELIGIOUS PREFERENCE		CHURCH					
OCCUPATION		MOTHER'S NAME		FATHER'S NAME			
LAST EYE EXAM		FLU SHOTS		PNUMOVAC			
FAMILY LAUNDRY	YES ☐ NO ☐	WEIGHT		HEIGHT			
CURRENT MEDICATIONS							
ALLERGIES							
DENTURES	UP ☐ DOWN ☐	EYEGLASSES ☐	HEARING AID ☐	OTHER			
CANE ☐	QUADCANE ☐	WALKER ☐	WHEELCHAIR ☐	OTHER			
MENTAL STATUS							
SPECIAL NEEDS							

FELONY CONVICTION	YES ☐ NO ☐						
IF YES BACKGROUND CHECK DATE							
PRE-SCREENING COMPLETE	YES ☐ NO ☐	DATE					
HILLCREST PAYEE FOR SS	YES ☐ NO ☐						
COMMENTS							

COMPLETED BY		REV 8-05 NURSING/ INQUIRY