Dallastown
NURSING CENTER

Application for Residency

717-244-2295 • www.dallastownnursingcenter.com
623 East Main Street, Dallastown, PA 17313

Resident Making Application - Date: _____

Last: _____ First: _____ Middle: _____ Sex: M | F

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Religion: _____ Eye Color: _____ Hair Color: _____

Marital Status: _____ Admitted from: _____

How were you referred?: _____

Social Security #: _____ Medicare #: _____

Other Insurance: _____

ID Number: _____ Group Number: _____

Family Physician: _____ Phone: _____

Podiatrist: _____ Phone: _____

Dentist: _____ Phone: _____

Optometrist: _____ Phone: _____

Audiologist: _____ Phone: _____

Hospital Preference: _____

Allergies: _____

Identifying Marks: _____

Ambulance Club: _____

Funeral Home: _____ Phone: _____

Will the resident be using our beautician / barber services? (circle one) Yes | No

If so, how often should they be scheduled? (circle one) weekly? | bi-weekly? | monthly?

Will our staff be doing the resident's laundry? (circle one) Yes | No

Who will be supplying the resident's medications?: _____

Responsible Financial Party *(for billing purposes)* -

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Relationship to resident: _____

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Application for Residency Form Continued

Emergency Contact #1:

Last: _____ First: _____ Middle: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone home: _____ work: _____ mobile: _____

Relationship to resident: _____

Emergency Contact #2:

Last: _____ First: _____ Middle: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone home: _____ work: _____ mobile: _____

Relationship to resident: _____

Emergency Contact #3:

Last: _____ First: _____ Middle: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone home: _____ work: _____ mobile: _____

Relationship to resident: _____

Date of Application: _____ Print Name: _____

Signature of person completing this form: _____