



717-244-9722 • www.dallastownnursingcenter.com
621 East Main Street, Dallastown, PA 17313

Resident's Name

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

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Religious Denomination: _____

Marital Status: _____ Admitted from: _____

Social Security #: _____ Medicare #: _____

Other Insurance: _____

ID Number: _____ Group Number: _____

Other Insurance: _____

ID Number: _____ Group Number: _____

Family Physician: _____ Physician's Phone: _____

Physician's Address: _____

Food and Medication Allergies: _____

Hospital Preference: _____ Living Will? Yes | No

Podiatrist: _____ Podiatrist Phone Number: _____

Funeral Home Preference: _____ Phone: _____

Wish to use our Beautician or Barber? Yes | No How Often? weekly | bi-weekly | monthly

Diet type (consistency): _____ Chewing / swallowing issues: _____

Food Preferences / Dislikes: _____

Lifetime Occupation: _____

Year of Education (highest level): _____

Do you drink alcohol?: Yes | No | Socially

Do you drink smoke?: Yes | No

Are you: Continent? | Incontinent?

Ambulation Status: _____

Usual wake up time is: _____ Bedtime is: _____ Naps: _____

Do you have a risk of falling?: Yes | No Recent fall date(s): _____

Daily routine (*circle all that apply*):

- Stay up late | Nap during day | I have hobbies | Spend most time alone | I attend church
- I attend synagogue | I find strength in my faith | I like to shower to bathe | I bathe in the evening
- I enjoyed the presence of animals at home | I like to be involved in group activities



Pre-residency Form Continued

Plan for discharge: temporary | short term | discharge not anticipated _____

Your dates for most immunizations: Influenza _____ Pneumonia _____

Responsible Financial Party (for billing purposes):

Last: _____ First: _____ Middle: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone home: _____ work: _____ mobile: _____

Relationship to resident: _____

Emergency Contact #1:

Last: _____ First: _____ Middle: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone home: _____ work: _____ mobile: _____

Emergency Contact #2:

Last: _____ First: _____ Middle: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone - home: _____ work: _____ mobile: _____

Emergency Contact #3:

Last: _____ First: _____ Middle: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone home: _____ work: _____ mobile: _____

Date of Application: _____ Print Name: _____

Signature of person completing this form: _____