Application for Residency

717-244-9722 • www.dallastownnursingcenter.com
621 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: ____

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: ______________