# RESIDENT INFORMATION SHEET

## *ADULT CARE HOME INFORMATION:*

| Operator Name: | Operator Phone Number: | Address: |
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## *PERSONAL INFORMATION:*

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| Resident legal name: | Original Admission Date: | Date Recently Updated: |
| Resident chosen/preferred name: | Pronouns: | |
| Social Security # | Medicare # | Medicaid # |
| VA# | Other Insurance: | Policy # |
| Legal sex: ☐ Male ☐ Female ☐ X/Not specified | Gender identity: ☐ Male ☐ Female ☐ Intersex ☐ Nonbinary ☐ Transgender ☐ 2 Spirit ☐ Other | |
| Birth Date: | Birthplace: | |

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| Hobbies/Interests: | Preferred Hospital: |
| Favorite Activities: | Case Manager & Telephone: |
| Food Likes/Dislikes: | Preferred Funeral Home Name and Telephone: |
| Other(please specify) | Faith/Worship affiliation: |

## *GENERAL INFORMATION:*

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| Prior living situation: Alone ☐ Family Member ☐ Assisted Living ☐ Foster Home ☐ Nursing Home ☐ Hospital ☐ Other | |
| Primary Physician's Name & Telephone: | Nurse's Name & Telephone: |
| Other Physician's Name and Telephone: | Other Health Professional's Name & Telephone: |
| Other Physician's Name and Telephone: | Dentist's Name & Telephone: |
| Other Physician's Name and Telephone: | Pharmacy Name & Telephone: |
| Power of Attorney & Telephone: | Legal Guardian |
| **Legal Representative:** | **Relationship:** |
| **Address (City, State, & Zip)** | **Telephone:** |
| **Relative:** | **Relationship:** |
| **Address (City, State, & Zip)** | **Telephone:** |
| **Relative:** | **Relationship:** |
| **Address (City, State, & Zip)** | **Telephone:** |
| Other Emergency Contacts | |

## *MEDICAL INFORMATION:*

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|---|---|
| (Please check all that apply) ☐ DNR ☐ Physician Directive ☐ POLST ☐ Advanced Directives ☐ Other: | Date: |
| **Diagnosis: (Please update when changed)** | |
| Home Health Agency: | |
| Allergies: | |

*Updated 10/15/2024*