Daily Grace Adult Day Health Services, Inc.

Client Application

I. CLIENT INFORMATION

CLIENT'S NAME: _____

HOME ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE NUMBER: (_ _ _) _ _ _ - _ _ _ _

SOCIAL SECURITY NO. _ _ _- _ _ - _ _ _ _

DATE OF BIRTH: _ _ /_ _ /_ _ _ _ BIRTH PLACE: _____

HOW DID YOU HEAR ABOUT US? _____

ENROLLMENT DATE: _ _ /_ _ / _ _ _ _

II. RESPONSIBLE PARTY/GUARDIAN INFORMATION

NAME: _____

LAST FIRST MIDDLE

ADDRESS: _____

STREET CITY STATE ZIP CODE

HOME PHONE: (_ _ _) _ _ _- _ _ _ _ MOBILE PHONE: (_ _ _) _ _ _- _ _ _ _

EMPLOYER: _____ WORK PHONE: (_ _ _) _ _ _- _ _ _ _

EMERGENCY CONTACTS

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____PHONE: (_ _ _) _ _ _-_ _ _ _

DRIVER'S LICENSE NUMBER: _____

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: (_ _ _) _ _ _- _ _ _ _

DRIVER'S LICENSE NUMBER: _____

III. PHYSICIAN INFORMATION

NAME OF PRIMARY CARE PHYSICIAN: _____

PRACTICE NAME _____

PRACTICE ADDRESS _____

STREET CITY STATE ZIP CODE

OFFICE PHONE: (_ _ _) _ _ _- _ _ _ _

LAST APPOINTMENT: _____ NEXT APPOINTMENT: _____

SPECIALIST: _____ SPECIALITY: _____

PHONE: (_ _ _) _ _ _- _ _ _ _

SPECIALIST: _____ SPECIALITY: _____

PHONE: (_ _ _) _ _ _ - _ _ _ _

IV. INSURANCE/BILLING INFORMATION

PLEASE SELECT METHOD OF PAYMENT: _____ PRIVATE PAY _____ INSURANCE

NAME OF INSURANCE PROVIDER: _____

PHONE: (_ _ _) _ _ _- _ _ _ _

GROUP NUMBER: _____ POLICY NUMBER: _____

MEDICARE NUMBER: _____

MEDICAID NUMBER: _____

****PHOTOCOPIES OF INSURANCE CARDS REQUIRED*****

CLIENT SIGNATURE: _____ DATE: _____

RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____

DAILY GRACE ADULT DAY SERVICES: _____ DATE: _____

FOR OFFICE USE ONLY- PLEASE DO NOT WRITE BELOW

INTAKE PROCESS COMPLETE: __ YES __ NO PATIENT ASSESSMENT: __ COMPLETE __ IN PROCESS PATIENT FILE COMPLETE: __ YES __ NO LISTED ON NATIONAL REGISTERED SEX OFFENDER REGISTRY? __ YES __ NO PATIENT SATUS: _ ACCEPTED _ DENIED _ PENDING STAFF INITIALS: _____ DATE: _____

V. SOCIAL HISTORY

WHO DOES THE CLIENT LIVE WITH? _____

RELATIONSHIP? _____

HIGHEST EDUCATIONAL LEVEL? _____ DID YOU GRADUATE? _____

HAVE YOU WORKED BEFORE? _____

REASON FOR UNEMPLOYMENT? _____

ARE YOU MARRIED/WIDOWED/DIVORCED? _____

DO YOU HAVE SUPPORT FROM FAMILY, NEIGHBORS, CHURCH MEMBERS, COMMUNITY AGENCY, HOME HEALTH CARE, PERSONAL CARE HOME? EXPLAIN.

_____

_____

_____

WHAT ARE YOUR FOOD LIKES?

WHAT TIME OF FOOD DO YOU DISLIKE?

_____
_____

DO YOU PARTICIPATE IN SOCIAL ACTIVITIES? EXPLAIN.

_____
_____
_____

HOW DO YOU SPEND YOUR LEISURE TIME?

_____

MEDICAL AND SOCIAL HISTORY

HAVE YOU EVER BEEN HOSPITALIZED? __ NO __ YES (PLEASE EXPLAIN AND INDICATE DATES)

_____
_____
_____

LIST CURRENT MEDICATIONS:

DRUG ALLERGIES:

_____

ALLERGIES:

_____

Daily Grace Adult Day Health Services, Inc.

MEDICAL DIAGNOSES/CONDITIONS:

ANY ACUTE OR CHRONIC ILLNESS? __NO __ YES (PLEASE EXPLAIN)

_____

_____

DO YOU REQUIRE OXYGEN? __ NO __ YES

CLIENT SIGNATURE: _____ DATE: _____

RESPONSIBLE PARTY SIGNATURE: _____DATE: _____

DAILY GRACE ADH SERVICES REP: _____ DATE: _____