

## RESIDENT DEMOGRAPHIC INFORMATION

Name \_\_\_\_\_ Date of Admission \_\_\_\_\_

Date of Birth \_\_\_\_\_ Birthplace \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_

Address Prior to Admission \_\_\_\_\_

Phone # \_\_\_\_\_

Social Security # \_\_\_\_\_ Medicare # \_\_\_\_\_ Medicaid # \_\_\_\_\_

Health Insurance Carrier/HMO \_\_\_\_\_ Policy # \_\_\_\_\_

Health Care Provider \_\_\_\_\_ Phone # \_\_\_\_\_

Case Manager \_\_\_\_\_ Phone # \_\_\_\_\_

Dentist \_\_\_\_\_ Phone # \_\_\_\_\_

Pharmacist \_\_\_\_\_ Phone # \_\_\_\_\_

Other Service Provider \_\_\_\_\_ Phone # \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Emergency Contact (1) \_\_\_\_\_ Phone # \_\_\_\_\_

Relationship to Provider \_\_\_\_\_

Emergency Contact (2) \_\_\_\_\_ Phone # \_\_\_\_\_

Relationship to Provider \_\_\_\_\_

Date of Discharge \_\_\_\_\_

Reason for Discharge \_\_\_\_\_

Place Discharged to  
Address \_\_\_\_\_