ASSISTED LIVING RESIDENCE RESIDENT PERSONAL DATA FORM

Resident's Name: ______________________ Facility Name: ______________________

SECTION 1: PERSONAL DATA Cont.: HEALTH INSURANCE

Insurer ______________ ID # __________

Medicaid No. ______________________

Medicare No. ______________________

Prescription Drug Plan (if any) ______________

Plan ID # ______________________

Other Health Care Coverage ______________

____

PHARMACY

Pharmacy(ies) ______________________

____

Phone ______________ Phone ______________

Address(es) ______________________

____

City ______________ State ______ Zip ______

SECTION 2: PERSONAL BACKGROUND

Wishes to be addressed as: ______________________

Address (if different from ALR): ______________________

Resident's Representative: ______________________

Relationship: ______________________

Address: ______________________

____

Phone: **Home** ______________

Work ______________

Cell ______________

Significant Other: ______________________

Relationship: ______________________

Address: ______________________

____

Phone: **Home** ______________

Work ______________

Cell ______________

Resident's Representative: ______________________

Relationship: ______________________

Address: ______________________

____

Phone: **Home** ______________

Work ______________

Cell ______________

Significant Other: ______________________

Relationship: ______________________

Address: ______________________

____

Phone: **Home** ______________

Work ______________

Cell ______________

Residential Background (born/raised, lived most of life): ______________________

____

Occupational/Educational Background: ______________________

____

Religious Affiliation (if any): ______________ **Place of Worship:** ______________ **Phone:** ______________

Health Care Proxy: ☐Yes ☐ No ______________________ **(Name)** **DNR:** ☐ Yes ☐ No

Power of Attorney: ☐ Yes ☐ No ______________________ **(Name)** **Living Will:** Yes ☐ No ☐

Burial Instructions: ______________________

____

New York State Department of Health
Division of Assisted Living

ASSISTED LIVING RESIDENCE RESIDENT PERSONAL DATA FORM

Resident's Name: ______________________ Facility Name: ______________________

ADMISSION / DISCHARGE INFORMATION

Date of Admission: ______________________ **County:** ______________

Admitted from: ☐ **Own Home** ☐ **Hospital** ☐ **NH** ☐ **OMH** ☐ **Other (specify):** ______________

Address Admitted from (Street, City, State, Zip): ______________________

Discharge Date: ______________ **Discharge to:** ☐ **Own Home** ☐ **Hospital** ☐ **NH** ☐ **OMH**

☐ **Other (Specify):** ______________________

Address Discharged to (Street, City, State, Zip Code): ______________________

Reason for Discharge: ______________________

____

SECTION 1: PERSONAL DATA

Date of Birth: ____/____/____ (Month Day Year) Gender: ☐ M ☐ F Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Partner

NOTIFY IN CASE OF EMERGENCY

Name ______________________

Relationship ______________________

Home: ______________ Work: ______________

Cell Phone: ______________ Other: ______________

Address ______________________

City ______________ State _____ Zip _______

ATTENDING PHYSICIAN

Name ______________________

Address ______________________

City ______________ State _____ Zip _______

Phone: ______________ Fax: ______________

OTHER HEALTH CARE PROVIDERS

Name ______________________

Specialty ______________________

Phone: ______________ Fax: ______________

Address ______________________

City ______________ State _____ Zip _______

Name ______________________

Specialty ______________________

Phone: ______________ Fax: ______________

Address ______________________

City ______________ State _____ Zip _______

OTHER HEALTH CARE PROVIDERS

Name ______________________

Specialty ______________________

Phone: ______________ Fax: ______________

Address ______________________

City ______________ State _____ Zip _______

Name ______________________

Specialty ______________________

Phone: ______________ Fax: ______________

Address ______________________

City ______________ State _____ Zip _______

Name ______________________

Specialty ______________________

Phone: ______________ Fax: ______________

Address ______________________

City ______________ State _____ Zip _______

AREA HOSPITAL / CLINIC OF CHOICE

Name ______________________

Address ______________________

Additional Information: ______________________

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