

Client Identifying Information

RESIDENT'S NAME: _____ RM# _____ DATE: _____

BIRTHDATE: _____ AGE: _____ SEX: F M SOC.SCRTY# _____

PRIVATE INS. CO.(name & number, if any): _____

MEDI-CAL# _____ MEDICARE#: _____

PRIMARY CARE PHYSICIAN: _____ PHONE () _____

ADDRESS: _____

PRIMARY DIAGNOSIS: _____

AMBULATORY STATUS: AMBULATORY NON-AMBULATORY WHEELCHAIR WALKER

ALLERGIES: _____

LEGAL GUARDIAN: _____

RELATIONSHIP TO CLIENT: _____

ADDRESS: _____

PHONE () _____ SECONDARY PHONE () _____

SECOND EMERGENCY CONTACT PERSON: _____

RELATIONSHIP TO CLIENT: _____

ADDRESS: _____

PHONE () _____ SECONDARY PHONE () _____

PREVIOUS ADDRESS: _____

RELIGIOUS PREFERENCE: _____