

# Senior & Residential Care Program



Phone: (509)574-6139 Fax: (509)574-6138

## Assisted Living / Adult Family Home Patient Registration Form

Name of facility where patient lives: \_\_\_\_\_

### Patient's Information

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Gender: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Patient's Marital Status: \_\_\_\_\_  Single  Married  Divorced  Widow  Separated

### Guarantor's Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### Emergency Contact

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Do you receive care from another clinician?  Yes\*  No

**\*If you checked "Yes", please provide us with the names of the clinicians below.**

\_\_\_\_\_

### If over 18 years old

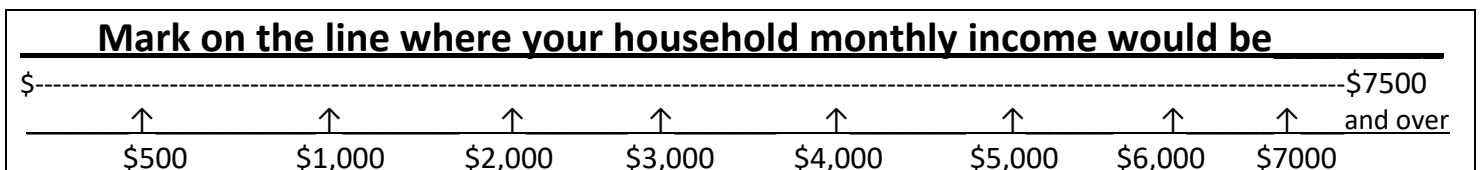
Advance Directive in place?  Yes\*  No  Living Will  DPOA  DNR  POLST

**\*If you checked "Yes", please provide us with a copy of the document**

Do you want more information regarding the Advance Directive?  Yes  No

**We appreciate that you selected us as your health care provider. We provide services to people with insurance, those with not enough insurance, and those without health insurance. Our clinic receives funding from the government that requires we collect and report information about our patient population; therefore we need you to answer the following questions:**

**What is your current household monthly income? (See chart below) \_\_\_\_\_**



Please provide copies of current insurance cards.



