Application Form #2
Friendsview Retirement Community

MEDICAL INFORMATION

Name: _____Date:_____
Last First Middle

Address: _____

Home Phone:_____ Cell Phone:_____

E-mail address:_____

Social Security Number:_____ Date of Birth:_____

Allergies:_____

List any dietary restrictions:_____

Medications	DOSE	Directions	For what condition?

Physician: _____
Name Phone Number

Dentist: _____
Name Phone Number

Ophthalmologist: _____
Name Phone Number

Mortuary: _____
Name Phone Number

Emergency Contacts (list in order to be called if needed)

Name	Relationship	Address	Phone Numbers
			Home: Work: Cell:
			Home: Work: Cell:
			Home: Work: Cell:

In case of hospitalization, would you like a church/pastor contacted? ____Yes ____No
If yes, please list church/pastor and phone number:_____

Insurance Information
Medicare: Part A ◯ Part B ◯ Claim Number: _____
Health Insurance:
Company: Policy# _____
Long Term Care Insurance
Company: Policy # _____

Do you have?

A Durable Power of Attorney?	Yes	No	Who?
Executor of your will?	Yes	No	Who?
Advanced Directive	Yes	No	Who?

Signature: _____ Date: _____