



Community Living Centers, Inc.

Admission Record

Patient's Name _____ Date _____ Time _____

Present Address _____

Home Address (If different) _____ Church Affiliation _____

Birth Date _____ Sex: ? Male ? Female Marital Status _____ Race _____

Social Security No. _____ Welfare Claim No. _____

Attending Physician _____ Address _____ Phone _____

Alternate Physician _____ Address _____ Phone _____

Name of Dentist _____ Address _____ Phone _____

Name of Pharmacist _____ Address _____ Phone _____

Mortician _____ Address _____ Phone _____

Expenses Paid By: Family _____ Insurance _____

Medicare _____ Social Security Number _____ Welfare _____

Admitting Diagnosis: _____

Admitting Service _____ Date of Last Admission _____

Allergies _____

Rehabilitation Potential _____

Hospital Insurance _____ Address _____ Policy No. _____

Burial Insurance _____ Address _____ Policy No. _____

Next of Kin or Legal Representative _____ Address _____ Phone _____

Hospital Preference _____

This patient has been informed of his physical and mental condition and plan of treatment. ___Yes ___No

If no, explain _____

Physician Signature _____

If this section is not signed by the physician this summary information has been transcribed from document(s) contained in this patient's clinical record which appropriately bear the physician's signature.

Signature of Transcribing Nurse: _____ Date _____

In Case of Emergency (Relative or Friend)

Name _____ Address _____

Relationship _____ Phone _____

Name _____ Address _____

Relationship _____ Phone _____

Name _____ Address _____

Relationship _____ Phone _____