A Nurses Touch Residential Care

Medical Data Statement

Please Print Clearly or Type

Resident Name: ____

1. Are you capable of Independent Living without help from anyone else? ☐ Yes ☐ No If no, please

   describe the type(s) of assistance you currently need: ______________________________

2. Health Condition: Please explain any major change in your general health in the past year and any chronic illness or disability: ______________________________
3. Medicare Number: ______________________________

   Supplemental Health Insurance: ____________________Insurer: Policy #: ________________
4. Please give the name, address, and telephone number of the primary physician:

   Name:______________________________

   Address: ______________________________

   Street Address Apt/Suite

   ____

   City State Zip Code

   Telephone No: ____________________ Last Seen: ____________________
5. Have you been hospitalized or incapacitated for more than two (2) weeks at a time during the last three (3) years?

   ☐ Yes ☐ No If yes, please explain such details as are necessary on a separate sheet of paper.
6. Have you ever been treated for depression, anxiety, or any other emotional disorder? ☐ Yes ☐ No
7. Have you ever been addicted to alcohol or drugs? ☐ Yes ☐ No
8. List all current medications you are currently taking: ______________________________

To the best of my knowledge, the above statements are complete and true.

Prospective Resident ______________________________ Date ____________________