Longview
an Ithacare Community

Assisted Living Residence/ Enhanced Assisted Living Residence Admission Evaluation Form

Name:_____ Sex:_____ Age:_____ Date:_____

Birthdate:_____ Desired Occupancy Date:_____ Marital Status:_____

Legal Residence:_____ Phone:_____

Religion:_____ Church Affiliation:_____

Social Security Number:_____ Date of issuance:_____

Medicare #:_____ Medicaid #:_____

Other Health Insurance:_____ Policy #:_____

Prescription Drug Plan:_____ ID #:_____

Physician:_____ Address:_____ Phone:_____

Other Health Care Provider(s):_____ Phone:_____

Eye Doctor:_____ Address:_____ Phone:_____

Dentist:_____ Address:_____ Phone:_____

Psychiatrist:_____ Address:_____ Phone:_____

Medical Equipment?:_____

_____

Present diagnosis:_____

Medical History:_____

_____

Current Medications (Include non-prescription drugs):_____

_____

_____

Prescribed Diet:_____

Allergies:_____