Clint L. Hines, Inc.

Residency Application

1. **Name:** ____
   Last First Middle

2. **Present Address:**____
   Street City State Zip

3. **How many years of residence at present address:**_______________________

Current status: ( ) Owner ( ) Renter ( ) Living with relatives ( ) Other, please explain:

____

4. **Home Phone: (_____)__________________** **Cell Phone: (______)________________**

5. **Date of Birth: _____/_____/_______** **Age:________**

6. **Social Security Number:______-____-______**
   If Applicable:
7. **Medicare #:_____-____-_______**

8. **Medicaid #:________________** **Do you plan on applying for Nursing Home Medicaid ___**

9. **Marital Status:** ( )Single ( )Married ( )Divorced ( )Widowed

10. **Spouse's Name:** ____
    Last First Middle
    If spouse is deceased, please list date of death: ______/_____/________

11. **e-mail Address:** ______________________________

12. **Current employer:** ( ) Yes ( ) No **Occupation:** _____________________
    If yes, please furnish information.

Name of company: ____

Address: ____

Street City State Zip

Work Phone: (_____) _______________

13. Date of Retirement: ______/______/______ **Occupation**:____________________

14. Please list health, supplemental, accident or long-term insurance policies:

A copy of your insurance card or policies is needed upon admission.

Health Insurance: ( ) Yes ( ) No

Name of Insurance Company: ____

Policy Number: _______________________ Telephone: (_____) ______________

Supplemental Health Insurance: ( ) Yes ( ) No

Name of Insurance Company: ____

Policy Number: _______________________ Telephone: (_____) ______________

Accident Insurance: ( ) Yes ( ) No

Name of Insurance Company: ____

Policy Number: _______________________ Telephone: (_____) ______________

Long-term Care Insurance: ( ) Yes ( ) No

Name of Insurance Company: ____

Policy Number: _______________________ Telephone: (_____) ______________

15. Do you manage your own financial affairs? ( ) Yes ( ) No

(If no, Please furnish information)

Name: ___________________________ Relationship: __________________

Address: ____

Street City State Zip

Home phone: (_____)_____________ Cell Phone: (_____)_____________

16. Do you have a Living Will or Advanced Directive? ( ) yes ( ) No

(If yes, please furnish a copy.)
Advance health care directives, also known as **living wills, advanced directives, or advanced decisions,** are instructions given by individuals specifying what actions should be taken for their own health in the event that they are no longer able to make decisions due to illness or incapacity. (source: Wikipedia)

Do you wish to fill out a Do Not Resuscitate Order (DNR)? ( ) yes ( ) No

17. **Do you have a Statutory Durable Power of Attorney?** ( ) yes ( ) No
(If yes, please furnish a copy.)

18. **Do you have a Health Care Durable Power of Attorney?** ( ) Yes ( ) No
(If yes, please furnish a copy.)

If No to questions 16-18, we can help you with these options upon admission if you so choose.

19. **Primary Physician:**

Name: ____

Address: ____
Street City State Zip

Office Phone: (_____) _________________ Fax: (_____)______________________

Specialist:

Name: ____

Address: ____
Street City State Zip

Office Phone: (_____) _________________ Fax: (_____)______________________

Other Physician:

Name: ____

Address: ____
Street City State Zip

Office Phone: (_____) _________________ Fax: (_____)______________________

EMERGENCY CONTACTS

20. In case of emergency, please contact:

A.) Name: ______________________________ Relationship: ____________________

Address: ____
Street City State Zip

Home Phone: (_____)______________ Cell Phone: (_____)_____________

Work Phone: (_____)______________

B.) Name: ______________________________ Relationship: ____________________

Address: ____
Street City State Zip

Home Phone: (_____)______________ Cell Phone: (_____)_____________

Work Phone: (_____)______________

C.) Name: ______________________________ Relationship: ____________________

Address: ____
Street City State Zip

Home Phone: (_____)______________ Cell Phone: (_____)_____________

Work Phone: (_____)______________

BILLING INFORMATION

21. Please send invoices/statements to:

Name: ______________________________ Relationship: ____________________

Address: ____
Street City State Zip

Home Phone: (_____)______________ Cell Phone: (_____)_____________

Work Phone: (_____)______________

PERSONAL /SOCIAL HISTORY

22. Home Church:_______________________________

23. Military service/ branch: ____

24. Hospital preference: ____

25. Funeral Home preference: ____

26. Pharmacy preference: ____

27. Felony conviction? ( ) Yes ( ) No
If, yes, please furnish information.

Offense:____________________________________ Date of conviction:______________

Prosecution detail: ____

28. Do you smoke or use tobacco products? ( ) Yes ( ) No

29. List any major surgeries or illness in the past year: ________________________________

____

30. List any specific limitations: ____

____

31. List any necessary information about personal/health history you would like us to know:

____

____

____

____

32. List of medications:

Prescriptions:

Name of Medication	Dose	Instructions	Prescribing Doctor

_______________________________ _____________________________ ___________

Applicant/ Resp. party signature Printed name Date