



ELM TERRACE GARDENS
 SKILLED NURSING FACILITY
 LANSDALE, PENNSYLVANIA

APPLICATION FOR RESIDENCE

660 NORTH BROAD STREET • LANSDALE • PENNSYLVANIA 19446-2361 • (215) 361-5600

Miss
 Name: Mrs. _____
 Mr. Last First Middle

Address: _____
 Street City State Zip Code

Phone Number: () _____ Birthdate: _____
 (MM, DD, YYYY)

Marital Status (Circle One): Married Single Widowed Divorced

Name of Spouse (Living or Deceased): _____

Number of Children: _____

Social Security Number: _____ Medicare Number: _____

Health Insurance Company: _____

ID Number: _____ Plan: _____ Group: _____

Power of Attorney: _____ Phone Number: () _____

Address: _____
 Street City State Zip Code

Emergency Contact: _____ Phone Number: () _____

Address: _____
 Street City State Zip Code

Church Affiliation: _____ Pastor's Name: _____

Phone Number: () _____

Funeral Director: _____ Phone Number: () _____

Referred by: _____ Desired date of residence: _____

Accommodation: _____ Semi-private _____ Private

- o. Do you have a persistent cough or cough up blood? _____ YES NO
- p. Low Blood Pressure _____ YES NO
- q. Emphysema or Chronic Lung Condition _____ YES NO
- r. Anemia _____ YES NO
- s. Have you had abnormal bleeding associated with surgery or trauma? _____ YES NO
- t. Do you bruise easily? _____ YES NO
- u. Have you ever required a blood transfusion? _____ YES NO
If yes, please explain the circumstances _____ YES NO
- v. Cataracts _____ YES NO
- w. Have you had surgery for cataracts? _____ YES NO
- x. Have you been treated for a tumor or growth _____ YES NO
If yes, please explain. _____ YES NO
- y. Memory loss _____ YES NO
- z. Difficulty speaking _____ YES NO
- aa. Paralysis _____ YES NO
- bb. Do you have any other disease, condition, or problem not listed above? _____ YES NO
If yes, please list. _____

5. Are you taking any of the following medications?

- a. Antibiotics or Sulfa Drugs _____ YES NO
- b. Anticoagulants (Blood thinners) _____ YES NO
- c. High Blood Pressure Medicine _____ YES NO
- d. Cortisone (Steroids) _____ YES NO
- e. Tranquilizers _____ YES NO
- f. Antihistamines _____ YES NO
- g. Aspirin _____ YES NO
- h. Insulin _____ YES NO
- i. Digitalis or drugs for heart trouble _____ YES NO
- j. Nitroglycerin _____ YES NO
- k. Other (Please list): _____ YES NO

6. Are you allergic or have you reacted adversely to:

- a. Local anesthetics _____ YES NO
- b. Penicillin or other antibiotics _____ YES NO
- c. Sulfa Drugs _____ YES NO
- d. Barbiturates, Sedatives, or Sleeping Pills _____ YES NO
- e. Aspirin _____ YES NO
- f. Iodine _____ YES NO
- g. Codeine or other Narcotics _____ YES NO
- h. Other (Please list): _____

7. Do you use any of the following:

- a. Glasses or contacts _____ YES NO
- b. Dentures or Partials _____ YES NO
- c. Wheelchair _____ YES NO
- d. Walker or Cane _____ YES NO

FINANCIAL STATEMENT

MONTHLY INCOME

Social Security	\$ _____	per month
Pension	\$ _____	per month
Dividends / Interest	\$ _____	per month
Rental / Mortgage Income	\$ _____	per month
Trust Income	\$ _____	per month
Other Income	\$ _____	

TOTAL MONTHLY INCOME

\$ _____

CAPITAL ASSETS

Cash (Savings & Checking)	\$ _____
Stocks and Bonds	\$ _____
Home/Other Real Estate	\$ _____
Automobile	\$ _____
Life Insurance	\$ _____
Other	\$ _____

TOTAL ASSETS

\$ _____

LIABILITIES (PER MONTH)

Mortgage Payment	\$ _____
Notes Payable / Endorsed	\$ _____
Personal Debts / Other	\$ _____

TOTAL LIABILITIES

\$ _____

AFFIRMATION

I hereby affirm that the information presented in this application is complete and correct to the best of my knowledge.

Signature: _____

Date: _____