



ELM TERRACE GARDENS
 PERSONAL CARE
 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
 Number of Children: _____
 Name of Spouse (Living or Deceased): _____

Social Security Number: _____ Spouse's Soc. Sec. No.: _____
 Power of Attorney: _____ Telephone Number: () _____
 Address: _____
 Street City State Zip Code

Emergency Contact: _____ Phone Number: () _____
 Address: _____
 Street City State Zip Code

What was / is your occupation? _____ Education: H.S. ___ College _____
 What are your hobbies or interests? _____

Church Affiliation: _____ Pastor's Name: _____
 Phone Number: () _____

Medicare Coverage? _____ Other Hospitalization Plan? _____

 Name of Company _____

Health Condition (briefly note handicaps, chronic disease, dietary requirements, etc.) _____

Desired date of residence at Elm Terrace Gardens: _____

Accommodation: _____ Semi-private _____ Private

7. Do you have any blood disorder such as anemia? _____ YES NO
8. Have you had surgery or x-ray for a tumor or other condition? _____ YES NO
9. Are you taking any drug or medicine? _____ YES NO
If so, what? _____
10. Are you taking any of the following medications?
- a. Antibiotics or Sulfa Drugs _____ YES NO
 - b. Anticoagulants (Blood thinners) _____ YES NO
 - c. Medicine for High Blood Pressure _____ YES NO
 - d. Cortisone (Steroids) _____ YES NO
 - e. Tranquilizers _____ YES NO
 - f. Antihistamines _____ YES NO
 - g. Aspirin _____ YES NO
 - h. Insulin, tolbutamide (Orinase) or similar drug _____ YES NO
 - i. Digitalis or drugs for heart trouble _____ YES NO
 - j. Nitroglycerin _____ YES NO
 - k. Other (Please list): _____
11. 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): _____
12. Do you have any disease, condition, or problem not listed above? _____ YES NO
(If so, please explain) _____
13. Do you have cataracts? _____ YES NO
14. Have you had surgery for cataracts? _____ YES NO
15. Are you wearing contact lenses? _____ YES NO
16. Do you wear dentures? _____ YES NO
17. Do you suffer from loss of memory? _____ YES NO
18. Do you have difficulty speaking? _____ YES NO
19. Do you have any paralysis? _____ YES NO
(If Yes, please explain) _____
20. Do you use a wheelchair? _____ YES NO
21. Have you ever used a wheelchair? _____ YES NO
22. Do you use a 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 / Other Income	\$ _____	per month
TOTAL MONTHLY INCOME	\$ _____	per month

CAPITAL ASSETS

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