Resident's Emergency Form & Information

Apt #_____ Tentative Move in date_____

Name of Resident_____ Physical MID_____

Social Security #_____Sex _____Male _____Female

Date of Birth_____ Age_____ Place of Birth_____

Marital Status_____Anniversary_____

(Former) Occupation_____ Phone #_____

Veteran / or Spouse: Yes_____ No_____ Branch_____

Emergency Contacts: (Please list in order to be contacted)

1. Name_____ Relationship_____

Address_____

City, State, Zip_____ Phone #_____

Work Number_____ E-Mail Address_____

2. Name_____ Relationship_____

Address_____

City, State, Zip_____ Phone #_____

Work Number_____ E-Mail Address_____

3. Name_____ Relationship_____

Address_____

City, State, Zip_____ Phone #_____

Work Number_____ E-Mail Address_____

Person Responsible for financials: (Refer to number on emergency contact list if the same)

Name_____Relationshiship_____

Address_____City, State, Zip_____

Phone Number_____

(Please Provide a copy of any power of attorney documents whether active or not)

Medical Power of Attorney _____

Drug or Food Allergies _____

Last Flu Shot Date _____ COVID Vaccination: Dose 1 _____ Dose 2_____

TABLE ROCK SENIOR LIVING

Resident's Emergency Form & Information Cont.

Insurance Provider_____ Member #_____

Medicare #_____Medicaid #_____

Physician _____ Phone_____

Address_____ Fax _____

Other Physician _____ Phone _____

Specialty _____ Fax _____

Address_____

Dentist _____ Phone _____

Address_____ Fax _____

Pharmacy Preference _____ Phone _____

Address _____ Fax_____

(If choosing to use community preferred pharmacy, please write Guardian and fill out attached agreement)

Home Health / Hospice Preference_____ Phone_____

Oxygen ____ Yes ____ No ____ Bottles ____ Concentrators ____ L/Min Supplier_____

Hospital Preference_____

Funeral Home Preference_____

Religious Preference _____

Name & Address of Clergyman or Religious Advisor _____

_____

Do you have a Living Will? ____ Yes ____ No (If yes, please provide a copy)

Other Advanced Directives (Including POLST) ____ Yes ____ No (If yes, please provide a copy)

Please note: if it is your wish to NOT receive CPR or other lifesaving heroic measures, we (and EMS crews) are required to have a physician order (POLST) on hand in order to comply.

Pet Moving in ____ Yes ____ No Name/Type_____

Veterinarian (name, address, phone) _____

Vehicle on Premises ____Yes ____ No License # _____

Make_____ Model _____ Color _____

TABLE ROCK SENIOR LIVING