

Pre-Admission Form

If you have any questions or need any assistance, please call our admission staff at 321-267-0060.

| Demographic Information | | |
|---|---|--|
| Name of Patient: | Birthdate: | Age: |
| | | |
| <input type="checkbox"/> Male <input type="checkbox"/> Female | Is Patient a U.S. Citizen? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Where has the patient been in the last 60 days? | | |
| <input type="checkbox"/> Home <input type="checkbox"/> ALF <input type="checkbox"/> Hospital <input type="checkbox"/> SNF <input type="checkbox"/> Other: | | |
| Patient's Social Security Number: | | |
| Financial Information | | |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Private Pay | |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Medicaid | |
| Name of Insurance: | Medicaid Number: | |
| | | |
| Insurance Policy Number: | | |
| Reason for Skilled Nursing Facility Placement | | |
| <input type="checkbox"/> Short term stay for therapy from hospital | <input type="checkbox"/> Long term stay for general care from hospital | |
| <input type="checkbox"/> Short term stay for therapy from home | <input type="checkbox"/> Long term stay for general care from home | |
| Last date admitted to hospital: | Last date discharged from hospital: | |
| | | |
| Current diagnosis or reason for hospitalization: | | |
| | | |
| | | |
| | | |
| | | |
| Contact Information | | |
| Name: | | |
| Relationship to Patient: | <input type="checkbox"/> Self <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Granddaughter <input type="checkbox"/> Grandson | |
| | <input type="checkbox"/> Niece <input type="checkbox"/> Nephew <input type="checkbox"/> Friend <input type="checkbox"/> Other: | |
| Phone: | | |
| Responsible Party: | <input type="checkbox"/> POA <input type="checkbox"/> Health Care Proxy <input type="checkbox"/> Health Care Surrogate | |
| | <input type="checkbox"/> Guardian <input type="checkbox"/> Other: | |