

MASONIC HOME OF DELAWARE, INC.
RESIDENT'S ADMISSION FACT SHEET

Name: _____

Room or Cottage: _____ Date of Admission: _____ DOB _____
Resident Phone #: _____ Race: _____ Marital status: S M W D
Address Prior to Entering Highfield: _____

Primary Physician: _____
Address: _____
Phone: _____ Fax: _____

Social Security#: _____
Medicare #: _____ Effective date: _____

Supplemental Insurance: _____
Address: _____
Phone: _____ ID#: _____ Group#: _____

Long Term Insurance: _____
Address: _____
Phone: _____ ID#: _____ Group#: _____

RX Plan: _____
Address: _____
PHONE: _____ RX BIN #: _____ RX PCN #: _____
RX Group#: _____ Issuer: _____ ID#: _____

Masonic Affiliation: Yes No Lodge & #: _____

IN CASE OF ILLNESS OR DEATH

1) Name: _____
Address: _____
Phone: (H) _____ Cell _____ (WK) _____
E-mail: _____

2) Name: _____
Address: _____
Phone: (H) _____ Cell _____ (WK) _____
E-Mail: _____

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3) Name: _____
Address: _____
Phone: (H) _____ Cell _____ (WK) _____
E-Mail: _____

ADDITIONAL INFORMATION

Financial Responsible Party:

Name: _____
Address: _____
Phone: _____ Cell: _____

Advance Directives: Yes No

Medical Power of Attorney: Yes No

Name: _____ Phone: _____

Executor: _____

Durable Power of Attorney: Yes No

Name: _____ Phone: _____

FUNERAL PLANS

Mortician _____ Phone: _____

Religion: _____ Church: _____

Pastor: _____ Phone: _____

Other Physicians: (Specialists)

Name: _____ Specialty: _____

Address: _____

Phone: _____ Fax: _____

Dentist: _____

Address: _____

Phone: _____ Fax: _____

Eye Doctor: _____

Address: _____

Phone: _____ Fax: _____