Saint Simeon's
TULSA'S SENIOR COMMUNITY

APPLICATION: PERSONAL INFORMATION

☐ HEALTH CARE CENTER	☐ ASSISTED LIVING	☐ ALZHEIMER'S/MEMORY
☐ Private ☐ Semi-Private	☐ Studio ☐ Suite	☐ Private ☐ Semi-Private
	☐ One Bedroom	

Please indicate any of the following documents that have been completed and provide a copy.

☐ D.N.R. CONSENT

☐ ADVANCED DIRECTIVE FOR HEALTHCARE (LIVING WILL)

☐ GUARDIANSHIP (NAME) _____

☐ POWER OF ATTORNEY (NAME) _____

PERSONAL INFORMATION

LAST NAME_____FIRST_____MIDDLE_____

SS#_____MARITAL STATUS _____SPOUSE'S NAME _____

HOME ADDRESS_____CITY/STZIP _____

TELEPHONE_____DATE OF BIRTH_____AGE_____SEX _____

PREVIOUS OCCUPATION_____EMPLOYER_____

HAVE ANY FAMILY MEMBERS RESIDED AT ST. SIMEON'S? ☐ Yes ☐ No

NAME_____RELATIONSHIP _____

RELIGIOUS INFORMATION

RELIGIOUS AFFILIATION _____

NAME OF CHURCH, CLERGY_____TELEPHONE_____

ADDRESS_____CITY/ST_____ZIP _____

NAME OF FUNERAL HOME_____TELEPHONE_____

ADDRESS_____CITY/ST_____ZIP _____

IN CASE OF EMERGENCY (NEXT OF KIN)

FULL NAME_____RELATIONSHIP_____

ADDRESS_____CITY/ST_____ZIP_____

BUS. PHONE_____HOME PHONE_____CELL PHONE _ EMAIL ADDRESS ____

_____

FULL NAME_____RELATIONSHIP_____

ADDRESS_____CITY/ST_____ZIP_____

BUS. PHONE_____HOME PHONE_____CELL PHONE _____

EMAIL ADDRESS _____

MEDICAL INFORMATION

DIAGNOSIS _____

KNOWN ALLERGIES _____

ATTENDING PHYSICIAN_____TELEPHONE_____

ADDRESS_____CITY/ST_____ZIP _____

DENTIST_____TELEPHONE_____

PHARMACY_____TELEPHONE _____

HOSPITAL PREFERENCE _____

EMSA TOTAL CARE ☐ Yes ☐ No

RESPONSIBLE PARTY

FULL NAME _____

ADDRESS_____CITY/ST_____ZIP_____

BUS. PHONE_____HOME PHONE_____CELL PHONE _____

EMAIL ADDRESS _____

INSURANCE INFORMATION

MEDICARE NAME (FROM CARD) _____

MEDICARE NUMBER _____

SECONDARY INSURANCE _____

POLICY NUMBER_____GROUP NUMBER _____

WHO REFERRED YOU TO SAINT SIMEON'S?

NAME_____

ADDRESS_____CITY/ST_____ZIP_____

BUS. PHONE_____HOME PHONE_____CELL PHONE _____

PLEASE INDICATE HOW YOU HAVE HEARD ABOUT SAINT SIMEON'S (circle all that apply)

☐Physician	☐Hospital Personnel	☐Case Manager	☐Church
☐Website	☐Yellow Page Listing	☐Magazine Ad	☐Radio Ad
☐Friend	☐Life Senior Services	☐Newspaper	☐Relative of a Resident
☐Alzheimer's Association		Other: _____	

I certify that this Application is made of my own free will and volition and that the information is correct to the best of my knowledge. I authorize and request that my attending physician, surgeon or other persons having direct, professional knowledge of my physical or mental health, past or present, provide to the staff of Saint Simeon's Episcopal Home any and all information relative to this Application.

_____ _____

Applicant or Representative Date

_____

Relationship