

Fort Bayard Medical Center/Fort Bayard State Veteran's Home
Admission Information

Please print clearly and fill out completely

_____			_____		
Last Name	First Name	Middle/Maiden Name			
_____			_____		
Mailing Address	City	State	Zip	County	

Sex: Male Female	Marital Status: _____	Religion: _____
Date of Birth: _____	Age: _____	Birth Place: _____
Ethnicity: Anglo Hispanic Black Asian Native American	Other: _____	
Social Security #: _____	Medicare #: _____	Medicaid #: _____
Pharmacy Coverage: _____	Other Insurance #: _____	

Veteran: <u>Y</u> <u>N</u>	Veteran Spouse: <u>Y</u> <u>N</u>	Parent of Veteran: _____
Service Connected disability: <u>Y</u> <u>N</u>	% Level: _____	Branch of Service: _____
Military service from: _____	to: _____	

Primary language: English Spanish Other: _____
Highest Level of Education (please be specific): _____
Occupation: _____

Parent/Spouse Information:
Father's Name: _____
Mother's Maiden Name: _____
Spouse's Name: _____ SS#: _____

In Case of No Legal Representative
Contact in Case of Emergency/Death

Name Relationship: _____

Mailing address Phone: Home: _____

City State Zip Work: _____
Other: _____

Responsible Party for Health Care Decisions (Indicate Primary):

Name Relationship: _____
(Surrogate/Power of Attorney/Guardian)

Mailing address: Phone: Home: _____

City State Zip Work: _____
Other: _____

Responsible Party for Health Care Decisions (Indicate Secondary)

Name Relationship: _____
(Surrogate/Power of Attorney/Guardian)

Mailing address Phone: Home: _____

City State Zip Work: _____
Other: _____

Has applicant ever been in a Nursing Home before? Yes No

If "yes", where? _____

Has placement been attempted at a facility closer to the applicant's home or relative's home? Y N

If "yes", when, where and why was placement not made? _____

Funeral Home/Burial Arrangements:

Choice of Funeral Home: _____ Telephone #: _____

Burial Plan: Y ___ N

Name of Funeral Home: _____ Telephone #: _____

Other Instructions/Special
Requests: _____

FOR OFFICIAL USE ONLY:

Medical Record #: _____ Unit: _____ Room/Bed: _____

Admission Date: _____ Admission Time: _____

Previous Admission: _____ Attending Physician: _____

Admitted from: _____