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: Y N Veteran Spouse: Y N Parent of Veteran: _____

Service Connected disability: Y N % 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

_____ Relationship: _____
Name

Phone: Home: _____

_____
Mailing address Work: _____

_____ Other: _____
City State Zip

Responsible Party for Health Care Decisions (Indicate Primary):

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

_____ Phone: Home: _____
Mailing address:

Work: _____

_____
City State Zip Other: _____

Responsible Party for Health Care Decisions (Indicate Secondary)

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

_____ Phone: Home: _____
Mailing address

Work: _____

_____
City State Zip 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: _____