

Pre-Admission Form

If you have any questions or need any assistance, please call our admission staff at 850-863-2066.

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: