**VISION SENIOR CARE RESIDENT PROFILE**

**5002 CHAMBLE TUCKER RD TUCKER, GEORGIA 30084**

**(770) 330 -7557**

**Emergency Information**

THIS FORM CONTAINS IMPORTANT INFORMATION NEEDED FOR THE EMERGENCY MEDICAL TEAM IN THE EVENT OF A MEDICAL EMERGENCY.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | | | | | | | **Sex** | | | **Race** | | | | **Marital Status** | | | | **CODE STATUS** | |
| Str**eet Address**  **5002 Chamblee Tucker Road** | | | **City/Town**  **Tucker** | | | | | | **State**  **GEORGIA** | | **County**  **Dekalb** | | | | | | **Zip Code**  **30084** | | |
| DOB: | **Birthplace** | | | | | | | | **Religion** | | | | **Move-In Date** | | | | | | **Room** |
| **Admitted From:** | | | | | | **Usual Occupation** | | | | | | **Served in U.S. Armed Forces?**  Yes No Unknown | | | | | | | |
| Diagnoses: | | | | | | | | | | | | | | | *ALLERGIES:*  DIET: | | | | |
| **POA/ Representative** | | | | | **Relationship** | | | **Address** | | | | | | | | | **Home**  **Work**  **Cell**  **Email** | | |
| **Person to notify in emergency** | | | | | **Relationship** | | | **Address** | | | | | | | | | **Home**  **Work**  **Cell**  **Email** | | |
| **Other Significant contacts** | | | | | **Relationship** | | | **Address** | | | | | | | | | **Home**  **Work**  **Cell** | | |
| **Social Security Number** | | | | **Medicare Number** | | | | | | **Other Insurance** | | | | | | | | | |
| **Hospital of Choice** | | | | | Address | | | | | | | | | | | **Phone**    fax | | | |
| **Attending physician** | | | | | **Address** | | | | | | | | | | | **Phone**    Fax: | | | |
| **Dentist** | | | | | **Address** | | | | | | | | | | | **Phone:**  Fax: | | | |
| **Podiatrist** | | | | | **Address** | | | | | | | | | | | **Phone:**  **Fax:** | | | |
| **Additional Health Provider Discipline:** | | | | | **Address** | | | | | | | | | | | **Phone:**  Fax: | | | |
| **Pharmacy:** | | | | | **Address** | | | | | | | | | | | **Phone:**  Fax: | | | |
| **Church** | | | | | **Address** | | | | | | | | | | | **Phone** | | | |
| **Mortuary Preference:** | | | | | Address | | | | | | | | | | | **Phone** | | | |
| **FINANCIAL**  **RESPONSIBLE PARTY** | |  | | | | | | | | | | | | | | | | | |

**Medication list is separate from this form**