

Application for Residency

RIVERVIEW PLACE

† CATHOLIC HEALTH INITIATIVES

Full Name:		Admission Date:	
Date of Birth:		Apartment No:	
Telephone:		Alternate ph:	
Email:			
Move Out Date:		Deceased Date:	
Moved to:			
Former Business/Profession:			
		Assisted living:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Marital Status:	Single <input type="checkbox"/>	Married <input type="checkbox"/>	Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>
Spouse Full Name and Middle Initial:			
Date of Spouse's death, if widowed:			
MEDICAL INFORMATION:			
Primary Care Physician:		Phone number:	
Specialist:		Phone number:	
Hospital Preference:		Clinic:	
Medical Insurance Company:		Policy number:	
Pharmacy Name:		Phone number:	
POWER OF ATTORNEY:			
Do you have a medical power of Attorney?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If Yes, is it on file at Riverview Place?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Name:		Relationship to you:	
Home Phone:		Cell Phone:	Work Phone:
LIVING WILL:			
Do you have a living will:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If yes, is it on file with Riverview Place?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
CPR:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	*
*Do not resuscitate (refer to health office)			
MORTUARY:			
Name & Town of Mortuary:			
Phone number:			

We need the following information to keep our resident history files accurate and up-to-date.

Your full name:		Apartment number:	
Your home phone:		Cell number:	



FIRST CONTACT:

Name:		Relationship:	
Address:			
City, State, Zip:			
Email Address:			
Home Phone:		Cell:	
		Work:	



Nearest Person to Contact in an Emergency (only if different than above):

Name:		Relationship:	
Address:			
City, State, Zip:			
Email Address:			
Home Phone:		Cell:	
		Work:	



SECOND CONTACT:

Name:		Relationship:	
Address:			
City, State, Zip:			
Email Address:			
Home Phone:		Cell:	
		Work:	



THIRD CONTACT:

Name:		Relationship:	
Address:			
City, State, Zip:			
Email Address:			
Home Phone:		Cell:	
		Work:	



May we add the above names to our mailing list?	Yes		No	
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RELIGIOUS:

Religious Denomination:	
Name of Church you are a member of:	
Address of your Church: City, State, Zip:	
Your Pastor's Name:	
Phone number:	

HEALTH INFORMATION:											
Name:			DOB:			M		F			
Medicare number:											
Drug Allergies:				Food Allergies:							
Recent Surgeries with dates:											
CONDITIONS: (check all that apply)											
No known conditions				Heart Valve Prosthesis							
Abnormal EKG				Hemodialysis							
Angina				Hypertension							
Aphasia				Hypoglycemia							
Asthma				Leukemia							
Atrial Fib				Lymphoma							
Cancer				Memory Impaired:							
Cataracts				Pacemaker							
Clotting Disorder				Renal Failure							
COPD				Seizure Disorder							
Congestive Heart Failure				Stroke							
Coronary Bypass Graft				Vision Impaired							
Diabetes		Insulin		Yes		No		Wear Glasses			
Eye Surgery - type											
Left:		Right:				Prosthesis type:					
Hearing Impaired				Pre-med before dental work:							
Hearing Aid:		L:		R:		No		Yes		If YES, what medication?	
				Medication:							
Special Conditions/Remarks:											

RIVERVIEW APARTMENT INFORMATION:								
Full Name:								
Complete Address:					Fargo , ND		58104-6427	
Monthly Rent \$:		Garage #:		Garage Rent \$:				
Make/Model of Car:		Year:		License #:				
Person Responsible for payment:								
RESERVATION/SECURITY DEPOSIT:								
Date Received:		Amount:		Check #:		Pet Fee:		
MEAL PLAN:								
NO:		YES:		30-31 Day:		15 Meals:		
Individual:				Other:				
Time: 5:00 PM		5:30 PM		Undecided:				
HOUSEKEEPING:								
NO:		YES:						
Weekly		Bi-Wkly:		Monthly:				
HOME HEALTH:								
NO:		YES:						
If YES, Name of Agency:								
KEYS:								
Given to:					Date:			
Apt:		Front Door:		Garage:				
Garage Door Opener:		Additional Keys Given to:						

I/We declare the above information given in this application to be true, full and complete. I/We give permission to verify the information given.

Signature

Date

Signature

Date