



FRIENDS HOUSE

Retirement Community

“Community Through Caring”

**RESIDENT MEDICAL & EMERGENCY**  
**INFORMATION FORM**

Name \_\_\_\_\_ Date Completed \_\_\_\_\_

Date of Birth \_\_\_\_\_ Apartment/House# \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_ Social Security # \_\_\_\_\_

***I would like the following persons notified in case of emergency (by order of preference):***

Name \_\_\_\_\_ Primary Telephone# \_\_\_\_\_

Address \_\_\_\_\_ Secondary Telephone# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Relationship to you \_\_\_\_\_

Name \_\_\_\_\_ Primary Telephone# \_\_\_\_\_

Address \_\_\_\_\_ Secondary Telephone# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Relationship to you \_\_\_\_\_

**Medical Information:**

1. Physician \_\_\_\_\_ Telephone# \_\_\_\_\_

Specialty \_\_\_\_\_ Address \_\_\_\_\_

2. Physician \_\_\_\_\_ Telephone# \_\_\_\_\_

Specialty \_\_\_\_\_ Address \_\_\_\_\_

Eye Doctor \_\_\_\_\_ Telephone# \_\_\_\_\_

Dentist \_\_\_\_\_ Telephone# \_\_\_\_\_

Preferred Hospital \_\_\_\_\_

Listing of Current Medications including herbal and over-the-counter):

Medication \_\_\_\_\_ for treatment of \_\_\_\_\_

Medication \_\_\_\_\_ for treatment of \_\_\_\_\_

Medication \_\_\_\_\_ for treatment of \_\_\_\_\_

Medication \_\_\_\_\_ for treatment of \_\_\_\_\_  
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**Allergies (include allergies to Medication):** \_\_\_\_\_  
\_\_\_\_\_

Please circle all that you wear or have:

Hearing Aid: left right both    Dentures: upper lower both

Pacemaker (if circled, please note model \_\_\_\_\_)    Glasses

**Have you ever been treated for:**

Alcohol/Drug Dependency:  Yes     No    Anemia:  Yes     No

Cancer:  Yes     No    Depression:  Yes     No

**I have a living will?**     Yes (Please provide a copy)     No

**I have a "Do Not Resuscitate" form or bracelet?**     Yes (Please provide a copy)     No

**I wear a special medical bracelet or pendant?**     Yes     No

If yes, please explain the reason \_\_\_\_\_

My Health Care Representative/Agent:

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**Financial and Insurance Information:**

Medicare# \_\_\_\_\_ Medicare Part D Plan \_\_\_\_\_

Supplemental Insurance Name \_\_\_\_\_ Policy# \_\_\_\_\_

Long Term Care Insurance Name \_\_\_\_\_ Policy# \_\_\_\_\_

Social Security# \_\_\_\_\_

**Copies** of Social Security Card, Medicare Card, Supplemental Insurance, Long Term Care Insurance, etc. will be requested and will be maintained in your file.

My Designated Power of Attorney:

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Funeral Director \_\_\_\_\_

(list name of Funeral Home or Person designed as Funeral Director if other than Funeral Home)

Church Affiliation:

Church Name \_\_\_\_\_ Address \_\_\_\_\_

Pastor Name \_\_\_\_\_

Does Friends House have your permission to contact your pastor in the event of hospitalization?  Yes  No

**Uses and Disclosure of Health Information:**

**Treatment:** Friends House may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of our location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstance, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of the health or safety of others.

**Transfer of Care:** If your medical condition should require a transfer of care to Friends House Assisted Living or Skilled Nursing care, Friends House may transfer medical and financial information on file with the Resident Director to expedite and assist with the admissions process.

**Resident Rights:** You have the right to request changes or updates to your health information. You have the right to request that we place additional restrictions on our use or disclosure of your health information.

I understand and agree with the uses of my health information, and understand the rights that I have regarding the privacy of this information.

Signature \_\_\_\_\_ Date signed \_\_\_\_\_

Please complete this form and return it to:

Resident Director, 17340 Quaker Lane, Sandy Spring, MD 20860