Participant Profile

General Information

Name of Participant: _____ **Prefers To Be Called:** _____
Address: _____
Phone Number: _____ **Living Arrangement:** _____
Birth Date: _____ **Age:** _____ **Sex:** Male_____Female_____ **Race:** _____
Marital Status: M S W D Never Married **Spouse's Name**: _____
Religion: _____ **Service Start Date**: _____ **Participant #:** _____
Medicare #: _____ **Medicaid #:** _____ **Medical History #:** _____
Primary Care Provider: _____
Address: _____
Phone Number(s): _____
Primary Responsible Party:_____
Address: _____
Phone Number(s): _____
Relationship: _____
2nd Responsible Party: _____
Address: _____
Phone Number(s): _____
Relationship**:** _____

Power of Attorney For Healthcare: _____**Activated?** Yes No
Guardian: _____ **of** Person Estate
Code Status Requested: _____Full Code (Resuscitation) _____DNR (Do Not Resuscitate)

Responsible Party For Payment: _____
Funding Source: Private Pay, COP, COPW, CIP, AFCSP, FC, UW, Other: _____

Referred by: _____
Address: _____
Phone Number(s): _____
Caseworker: _____

Primary Care Physician: _____ Phone: _____
Psychiatrist (if applicable)**:** _____ Phone: _____
Neurologist (if applicable)**:** _____ Phone: _____

Medical Information

Medical Condition(s):

_____
_____
_____
_____
_____
_____
_____

Medication(s):

_____
_____
_____
_____
_____
_____
_____

Allergies/Sensitivities: _____ **Diet:** _____

I have completed the above information to the best of my knowledge and I believe it is true and accurate.

Participant or Responsible Party Signature _____ Date: _____