Harmony Homes
Assisted Living | Memory Care

40 Briggs Way Durham, NH 03824 • (P) 603-292-5175 • (F) 603-397-5578 • www.HarmonyHomesNH.com

# Admission Application

I am applying for (circle one of the following): Assisted Living Memory Care Respite Care

## General Information

Applicant's Name: _____ Sex: _____
Legal Address: _____
DOB: ____/____/____ Place of Birth: _____ Marital Status: _____
Email Address: _____ Religion:_____
Veteran: ___Yes ___ No Veteran Spouse: ___ Yes ___ No Have VA Benefits: ___Yes ___No

Legally Competent: ___ Yes ____ No (If No, Please Attach DPOA or Guardianship Papers)
Durable Power of Attorney: ____ Yes ____ No Guardianship: ___ Yes ___ No
Name of DPOA: _____
Address: _____ Phone #: _____
Name of Guardian: _____
Address: _____ Phone #: _____
Preferred Hospital: _____

## Insurance

Social Security # ____-____-_____ Long Term Care Insurance: _____
Medicare: # _____ Medicaid #: _____
Other Health Insurance: _____ Policy #: _____
Note: Please provide copies of all insurance cards (front and back)

## Contact Information

Responsible Party's Name: _____Relationship:_____
Address (if different from above): _____
Home Phone #:_____ Cell #: _____ Work #: _____

Additional Contact Person: _____ Relationship: _____
Address: _____ Phone: _____

Additional Contact Person: _____ Relationship: _____
Address: _____ Phone: _____

Responsible Person for Billing (If same as responsible party leave blank): _____
Address: _____ Phone: _____
Would you like Harmony Homes to Send You Invoices Via Email: ____ Yes ____ No
If Yes, What Email Would You Like Invoices Sent To: _____

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## Physicians/Associated Health Practitioners

Primary Care Physician: _____ Phone #: _____
Address: _____ Fax #: _____

Cardiologist: _____ Phone #: _____
Address: _____ Fax #: _____

Psychologist: _____ Phone #: _____
Address: _____ Fax #: _____

Psychiatrist: _____ Phone #: _____
Address: _____ Fax #: _____

Optometrist: _____ Phone #: _____
Address: _____ Fax #: _____

Dentist: _____ Phone #: _____
Address: _____ Fax #: _____

Other Care Provider Name: _____ Phone #:_____
Address: _____

Other Care Provider Name: _____ Phone #:_____
Address: _____

## Current and Past Medical History

What is the Resident's Current Condition: _____
_____
Discharge Plan/Home Situation: _____
Medical Diagnoses: _____
_____
(Cardiovascular, Respiratory, Neurological)

Past Medical History (please check all that apply):

| | | | |
|---|---|---|---|
| ____ Cancer | ____ Depression | ____Hypertension | ____Stroke |
| ____ Diabetes | ____ Anxiety | ____Heart Disease | ____Obesity |
| ____ Heart Murmur | ____ Pneumonia | ____ Dysphagia | ____ High Cholesterol |
| ____ COPD | ____ Asthma | ____ Epilepsy | ____ Cataracts |
| ____ Kidney Disease | ____ Kidney Stones | ____ Crohns | ____ IBD |
| ____ Anemia | ____ Dementia (please specify stage_____) | | |

Diet: _____ Known Allergies: _____

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**Funeral Home Arrangements**
(We Only Require the Name of the Funeral Home and Number)

Name:_____ Phone: _____

**List Any Other Information You Feel Pertinent To This Application:**

_____
_____
_____
_____
_____

How did you hear about us? _____

_____
Printed Name

_____
Signature

_____
Date