San Gabriel
memory care

2509 Frank Watson Parkway
Highland, Illinois, 62249
(618) 651-4444 | SanGabrielMemoryCare.com
sangabrielmc2015@gmail.com

GENERAL INFORMATION

Today's Date: _____ Move-in Date: _____ Move-out Date: _____
Applicant's Full Name: _____ Birthdate: _____
Present Address: _____
City, State, Zip: _____
Phone: _____

EMERGENCY CONTACT

In case of emergency, please contact: _____
Name: _____ Relationship: _____
Daytime Phone: _____ Evening Phone: _____
Address: _____
Email Address: _____

SECONDARY EMERGENCY CONTACT

Name: _____ Relationship: _____
Daytime Phone: _____ Evening Phone: _____
Address: _____
Email Address: _____

POWERS OF ATTORNEY

Name of Financial Power of Attorney: _____
Phone: _____
Name of Healthcare Power of Attorney: _____
Phone: _____

RELEASE OF MEDICAL INFORMATION

In case of medical emergency, (e.g., ambulance, hospital services), I authorize San Gabriel to release medical information to outside medical services. I also authorize San Gabriel to receive information about my (my loved one's) medical records from Doctors' offices, hospitals and other medical services.

Signed: _____ Date: _____

Please complete page 2 on the back of this form.

MEDICAL INFORMATION

Primary Diagnosis(es): _____

_____

_____

Known Allergies: _____

General Physician: _____ Phone: _____

INSURANCE INFORMATION

Medicare Number: _____ Part A: _____

Part B: _____

Social Security Number: _____

Supplemental Insurance Information: _____

Name of Carrier: _____

Group Number / Policy Number: _____

Address: _____

City / State / Zip: _____

Phone: _____

AGREEMENT INFORMATION

I attest that the above information is correct. I understand that my (my loved one's) health and general status will be reviewed regularly to ensure that San Gabriel Memory Care continues to be an appropriate environment for me (my loved one).

Signed: _____ Date: _____

Signed: _____ Date: _____

San Gabriel Representative: _____ Date: _____