Pre-Admission Form

LINCOLNTON REHABILITATION CENTER

If you have any questions or need any assistance, please call our admission staff at 704-732-1138.

Demographic Information

Name of Patient:	Birthdate:	Age:

❏ Male ❏ Female	Is Patient a U.S. Citizen?	❏ Yes ❏ No

Where has the patient been in the last 60 days?

❏ Home   ❏ ALF   ❏ Hospital   ❏ SNF   ❏ Other:

Patient's Social Security Number:

Financial Information

❏ Medicare   ❏ Private Pay

❏ Insurance   ❏ Medicaid

Name of Insurance:	Medicaid Number:

Insurance Policy Number:

Reason for Skilled Nursing Facility Placement

❏ Short term stay for therapy from hospital   ❏ Long term stay for general care from hospital

❏ Short term stay for therapy from home   ❏ Long term stay for general care from home

Last date admitted to hospital:	Last date discharged from hospital:

Current diagnosis or reason for hospitalization:

Contact Information

Name:	
Relationship to Patient:	❏ Self ❏ Daughter ❏ Son ❏ Granddaughter ❏ Grandson

❏ Niece ❏ Nephew   ❏ Friend   ❏ Other:

Phone:	
Responsible Party:	❏ POA ❏ Health Care Proxy ❏ Health Care Surrogate

❏ Guardian   ❏ Other: