# *Pre-Admission Form*

SARASOTA POINT REHABILITATION CENTER

If you have any questions or need any assistance, please call our admission staff at 941-331-4362.

## 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: