

Pre-Admission Form

If you have any questions or need any assistance, please call our admission staff at 919-231-6150.

Demographic Information		
Name of Patient:	Birthdate:	Age:
<input type="checkbox"/> Male <input type="checkbox"/> Female	Is Patient a U.S. Citizen?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Where has the patient been in the last 60 days?		
<input type="checkbox"/> Home <input type="checkbox"/> ALF <input type="checkbox"/> Hospital <input type="checkbox"/> SNF <input type="checkbox"/> Other:		
Patient's Social Security Number:		
Financial Information		
<input type="checkbox"/> Medicare	<input type="checkbox"/> Private Pay	
<input type="checkbox"/> Insurance	<input type="checkbox"/> Medicaid	
Name of Insurance:	Medicaid Number:	
Insurance Policy Number:		
Reason for Skilled Nursing Facility Placement		
<input type="checkbox"/> Short term stay for therapy from hospital <input type="checkbox"/> Long term stay for general care from hospital <input type="checkbox"/> Short term stay for therapy from home <input type="checkbox"/> 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:	<input type="checkbox"/> Self <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Granddaughter <input type="checkbox"/> Grandson <input type="checkbox"/> Niece <input type="checkbox"/> Nephew <input type="checkbox"/> Friend <input type="checkbox"/> Other:	
Phone:		
Responsible Party:	<input type="checkbox"/> POA <input type="checkbox"/> Health Care Proxy <input type="checkbox"/> Health Care Surrogate <input type="checkbox"/> Guardian <input type="checkbox"/> Other:	