



ElderCare
RESOURCES, INC.

CLIENT INFORMATION

Name: _____
Address: _____ DOB: _____
_____ SS # _____

Client Phone: _____ Alt Phone: _____

Client lives with (name): _____ Relation: _____
Phone: _____ E-mail: _____

Primary Contact Name: _____ Relation: _____
Address: _____ Phone: _____
_____ Alt Phone: _____
_____ E-mail: _____

Client's Diagnoses: _____

Client's Primary Concerns (Health, Daily Living, Safety, etc): _____

Allergies (medications, other): _____

Primary Physician Name: _____ Phone: _____
Clinic/Address: _____

Other Physician Name: _____ Phone: _____
Clinic/Address: _____ Specialty: _____

Other Provider Name: _____ Phone: _____
Clinic/Address: _____ Specialty: _____

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Client Name _____

Medicare #: _____

Effective dates Part A: _____ Part B: _____

Secondary Insurance Company (or Medicare Supplement): _____

Address: _____

Group/ID #s: _____ Phone: _____

Medicare Part D (Prescriptions) Company Name: _____

Address: _____

Group/ID #s: _____ Phone: _____

Attorney: _____

Phone: _____

Address: _____

Practice: Elder Estate

Advanced Directive: Y N Where kept: _____

POLST: Y N Where kept: _____

Financial POA: _____ Phone: _____

Health Care POA: _____ Phone: _____

Guardian: _____ Phone: _____

Conservator: _____ Phone: _____

Other Contacts (persons closely involved with the client):

Name: _____ Relation: _____

Address: _____ Phone: _____

_____ Alt Phone: _____

_____ E-mail: _____

Name: _____ Relation: _____

Address: _____ Phone: _____

_____ Alt Phone: _____

_____ E-mail: _____

Name: _____ Relation: _____

Address: _____ Phone: _____

_____ Alt Phone: _____

_____ E-mail: _____

Name: _____ Relation: _____

Address: _____ Phone: _____

_____ Alt Phone: _____

_____ E-mail: _____

Referred by: _____

Other Information: _____
