



**ElderCare**  
RESOURCES, INC.

### CLIENT INFORMATION

Date: \_\_\_\_\_

Intake: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ SS # \_\_\_\_\_

\_\_\_\_\_ DOB: \_\_\_\_\_

E-mail: \_\_\_\_\_ Phone: \_\_\_\_\_

Family/Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Client Primary Concerns: \_\_\_\_\_

\_\_\_\_\_

Diagnoses: \_\_\_\_\_

Allergies (medications, other): \_\_\_\_\_

Primary Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Clinic/Address: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Group #: \_\_\_\_\_ ID #: \_\_\_\_\_

Named insured: \_\_\_\_\_

Medicare: \_\_\_\_\_ Medicaid: \_\_\_\_\_

Attorney: \_\_\_\_\_ Phone: \_\_\_\_\_

Firm/Address: \_\_\_\_\_

Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Conservator: \_\_\_\_\_ Phone: \_\_\_\_\_

POA: \_\_\_\_\_ Phone: \_\_\_\_\_

Type of POA: \_\_\_\_\_ Document Location: \_\_\_\_\_

Advance Directive? \_\_\_\_\_ Document Location: \_\_\_\_\_

POLST: Y N Where: \_\_\_\_\_ Mortuary: \_\_\_\_\_

Referred by: \_\_\_\_\_

Bill To: \_\_\_\_\_

Contact 1: \_\_\_\_\_

Contact 2: \_\_\_\_\_

Notes: \_\_\_\_\_

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