Today's Date _____

RESIDENT PERSONAL INFORMATION

Legal Name _____ Preferred Name _____

Date of Birth _____ Social Security Number _____

Apartment / Cottage Number _____

Phone Number _____ Email _____

Medicare Number _____ Supplemental Insurance _____

May we share your birthday/anniversary dates with the community? ◯ YES ◯ NO

If applicable Spouse/Partner _____ Wedding Anniversary _____

Vehicle Make _____ Model_____Color _____ License Plate _____

Please provide copies of your Social Security and Medicare cards with this sheet.

Emergency Contact Information

In case of emergency, notify: (In order of preference)

Name 1 _____ Relationship _____

Address _____ Phone Number _____

_____ Alternate Number_____

Name 2 _____ Relationship _____

Address _____ Phone Number _____

_____ Alternate Number_____

Name 3 _____ Relationship _____

Address _____ Phone Number _____

_____ Alternate Number_____

Advance Directives

Power of Attorney _____ Documents Attached ◯ YES ◯ NO

Address _____ Phone Number _____

Healthcare Power of Attorney _____ Documents Attached ◯ YES ◯ NO

Address _____ Phone Number _____

Living Will ◯ YES ◯ NO Documents Attached ◯ YES ◯ NO

PROCEED TO NEXT PAGE

Today's Date _____

MEDICAL INFORMATION

Legal Name _____ Date of Birth _____
Code Status: ☐ Full Code ☐ DNR DNR attached? ◯ YES ◯ NO *Only originals are valid; no copies*
Medical Orders for Scope of Treatment (MOST) Form: ◯ YES ◯ NO
MOST attached? ◯ YES ◯ NO *MOSTs expire yearly. Valid originals only; no copies*
Advance Directive: ◯ YES ◯ NO Advanced Directive attached? ◯ YES ◯ NO
Primary Physician _____ Phone Number_____
Specialist(s) _____
Dentist _____ Phone Number_____
Pharmacy _____ Hospital Preference _____

Medical Devices

___ No medical devices

Or check the box of **any** medical device you routinely use, noting any specifics:

Y/N	Device	Notes	Y/N	Device	Notes
	Cane			Oxygen	If yes: CONT/PRN/HS Liters: ____ Supplier: _____
	CPAP/BIPAP			Pacemaker	
	Defibrillator			Scooter	
	Dentures	If yes: UPPER/LOWER/BOTH		Walker	
	Eyeglasses			Wheelchair	
	Hearing Aid(s)			Other:	

Comments:

Allergies

___ No known allergies (NKA)

Or list all allergies here:

Allergy:	**Reaction:**
Allergy:	**Reaction:**
Allergy:	**Reaction:**

Comments:

PROCEED TO NEXT PAGE

Today's Date _____

Surgery History

___ No past surgeries

Or list surgeries here:

Surgery	Date/Year of Surgery	Surgeon

Comments:

Medications

List **all** medications you take, including prescriptions, supplements, and as-needed (PRN) medications:

Medication Name	Reason Taking	Dose	Frequency

Comments:

PROCEED TO NEXT PAGE

Today's Date _____

Diagnoses

Please check **all** diagnoses you have, noting details, especially for those in bold:

☐	AFib (atrial fibrillation)	☐	Depression	☐	Hypoglycemic	☐	Seizures/Epilepsy
☐	Anemia	☐	Diabetes: T1/T2	☐	Incontinence	☐	Sleep Apnea
☐	**Arthritis**	☐	Dizziness	☐	Insomnia	☐	**Stroke/TIA**
☐	Asthma	☐	Fibromyalgia	☐	Jaundice	☐	Thyroid Disease
☐	Bleeding Disorder	☐	GERD	☐	Kidney Disease	☐	Tremors
☐	BPH (benign prostatic hyperplasia)	☐	Glaucoma	☐	Macular Degeneration	☐	Ulcer
☐	CAD (coronary artery disease)	☐	Gout	☐	Memory Impairment	☐	Vascular Disease
☐	**Cancer**	☐	Headaches/Migraines	☐	Multiple Sclerosis	☐	Vertigo
☐	Cataracts	☐	Hearing Impairment	☐	**Neuropathy**	☐	Vision Impairment
☐	CHF (congestive heart failure)	☐	Hernia	☐	Osteoarthritis	☐	**Other:**
☐	**Chronic Pain**	☐	High Blood Pressure	☐	Osteoporosis	☐	**Other:**
☐	COPD	☐	High Cholesterol	☐	Parkinson's	☐	**Other:**

Comments:

Please share any additional medical comments or concerns:

PROCEED TO NEXT PAGE

Today's Date _____

FINAL WISHES

Funeral Home _____ Phone Number _____

Prearrangements Made? ◯ YES ◯ NO Organ Donor? ◯ YES ◯ NO

Executor of Estate _____ Phone Number _____

Attorney _____ Phone Number _____

Special Instructions _____

_____

_____

Carolina Village Memorial Service? ◯ YES ◯ NO If Yes, Performed By _____

Religious Affiliation (optional) _____

PROCEED TO NEXT PAGE

Today's Date _____

PRIVATE HEALTH INFORMATION

Resident Name _____

Below, please list the name(s) of individuals that we may disclose your private health information to.

(Example: A resident/family member/friend calls ILS and asks if you are in the hospital. If the person's name is listed below, we may disclose your health information/status as requested by the person. If the person's name is NOT listed below, we will not disclose any of your health information.)

1. Name: _____ Contact Number: _____

2. Name: _____ Contact Number: _____

3. Name: _____ Contact Number: _____

4. Name: _____ Contact Number: _____

5. Name: _____ Contact Number: _____

6. Name: _____ Contact Number: _____

7. Name: _____ Contact Number: _____

8. Name: _____ Contact Number: _____

9. Name: _____ Contact Number: _____

10. Name: _____ Contact Number: _____

PROCEED TO NEXT PAGE

Today's Date _____

FINANCIAL CONTACT PERSON

We ask that you have a contact person on file who can serve as a point of contact for financial questions specifically. We will contact this person only if your account requires attention, such as if there is a distinct change in payment pattern, if it becomes delinquent for more than 90 days, if an individual health event occurs that requires outside assistance, etc. This person should be a trusted individual who can assist you with your finances, should the need arise. This person may be your durable/financial Power of Attorney, but is not required to be.

Name _____ Relationship _____

Address _____ Phone Number _____

_____ Alternate Number _____

Special Instructions _____

_____

_____

Return this completed form to Brent Thomas.

Keep us informed of any personal information updates by contacting ILS at 828-233-0625.

Image Release

I, _____, hereby grant to Carolina Village permission to use photographs, audio recordings, or videotape recordings of me, and their transcripts where applicable, in whole or in part. Additionally, I grant Carolina Village permission to use, at its discretion, my name in connection with the image/recording. I understand that the images/recordings may be used in print publications, online publications, presentations, websites, social media, or other established media.

Furthermore, I understand that no royalty, fee, or other compensation shall become payable to me by reason of such use. I hereby release Carolina Village and its employees from any and all claims and demands arising out of, or in connection to, the use of the images/recordings.

I have read and understand this Image Release and I agree to its terms.

Printed Name: _____

Signature: _____

Address: _____

City, State, Zip: _____

Phone: _____

Date: _____

If person listed above is under age 18 or has a Legal Power of Attorney:

I, _____, am the legal guardian or Power of Attorney of the individual named above, have read this Image Release, and approve of its terms.

Guardian's Printed Name: _____

Guardian's Signature: _____

Date: _____

Return this completed form to Brent Thomas.

Ver. 01/19/2022

SHARED RESIDENT BIOGRAPHY

Information that you include here will be shared with Carolina Village community members.
Providing information on this sheet is optional.

NAME: _____

EMAIL: _____

PHONE (CELL OR CAROLINA VILLAGE HOME): _____

BIRTHDAY: _____

WEDDING ANNIVERSARY: _____

MOVE IN DATE: _____

PETS: _____

BIOGRAPHY: _____

Photo

_____

_____

_____

FAMILY: _____

_____

EDUCATION: _____

CAREER: _____

_____

HOBBIES: _____

_____

ORGANIZATIONS: _____

_____

MORE ABOUT ME: _____

_____

Return this completed form to Brent Thomas.

Ver. 01/19/2022