



Phillips-Strickland House

Application for Admission

CURRENT INFORMATION

Name: _____ Date of Application: _____

Current Address: _____ Male or Female: _____

_____ Telephone No.: _____

_____ Soc. Sec. No.: _____

How long have you lived in the Bangor area? Medicare No.: _____

_____ Medicaid No.: _____

HISTORY

Birth Date: _____ Place of Birth: _____

Father's Name: _____

Mother's Name: _____

Spouse(s): _____ Soc. Sec. No.: _____

Date of Marriage(s): _____ Where: _____

When:

Marital Status (please check one): Married: _____ Single: _____

Widowed: _____ Divorced: _____

Names of Children: _____ Address: _____ Telephone No.: _____

MEDICAL INFORMATION

Physician's Name:

Address:

Telephone:

Health Insurance Company and Policy ID Number:

Medical Problems

Handicaps:

Allergies:

Other problems:

LEGAL INFORMATION

Legal Guardian Yes No

Name of Legal Guardian:

Address:

Other Legal Oversight Yes No

Durable Power of Attorney/Health Care _____

Name, address, & telephone

Durable Power of Attorney/Financial _____

Name, address, & telephone

Responsible Family Member _____

Name, address, & telephone

Self _____

Legal Conservator Yes No

Name of Legal Conservator:

Address:

Telephone:

EDUCATION AND EMPLOYMENT HISTORY

Education (please check one):

No formal schooling:

8th grade or less:

9th-11th grade:

High School:

Technical or Trade School:

Bachelor's Degree:

Graduate Degree:

Other: _____

Former Occupation: _____

Military Service (please list branch and dates): _____

LIVING ARRANGEMENTS

Do you live alone? Yes No

Are you living at another facility? Yes No

Currently residing in: Private Home or Apartment
 Another Boarding or Assisted Living Home
 Nursing Home
 Acute Care Hospital
 Psychiatric Hospital
 MR/DD Facility
 Rehabilitation Hospital
 Other (please specify): _____

SPECIAL INTERESTS

Organizations you have belonged to:	Number of years:	Offices held:

Special Interests or Hobbies:

Church Affiliation (optional): _____

PERSONAL PREFERENCES

Please check any of the following advanced directives that apply to you:

Living will: ___

Do not resuscitate (DNR): ___

Do not hospitalize: ___

Organ donation: ___

Other (please specify):

Funeral Home Preference:

Mortuary Trust: _____

Cemetery Lot: _____

Location: _____

Relatives and friends to be notified in case of emergency:

Name:

Address:

Telephone:

Signature of Applicant

Date

Signature of person filling out this application if other than applicant

Telephone No.