



Admitting Record

Page 1 of 1

Resident		Room									
CASE NUMBER				PRIMARY/SECONDARY PAYOR				SOCIAL WORKER			
USUAL RESIDENCE STREET				STATE/ZIP		CITY-TOWN		MEDICARE PART A/B/D			
RACE		MARITAL		DATE OF BIRTH		AGE		SOCIAL SECURITY NO.		HMO / MANAGED CARE	
BIRTHPLACE STATE / COUNTRY			CITIZEN OF U.S.A.		RELIGION		MEDICARE/MEDICAID #		INSURANCE AUTHORIZATION #		
DATE ADMITTED			A.M. TIME P.M.		SEX		ROOM NO.		INS. CASE MANAGER		
									Tel: Fax:		
ADMITTING DIAGNOSIS											

PHYSICIANS NAME				ADDRESS				PHONE		MOTHERS NAME		FATHERS NAME	
ADMITTED FROM				HOW TRANSFERRED				REFERRED BY		INITIAL ADMISSION DATE			
DIALYSIS SCHEDULE										HEALTH INSURANCE CLAIM NO.			

NEXT OF KIN OR PERSON TO BE NOTIFIED						RELATIONSHIP		EMAIL		
ADDRESS				CITY		STATE		ZIP		
HOME PHONE		CELL PHONE				WORK PHONE			FAX	

NEXT OF KIN #2						RELATIONSHIP		EMAIL		
ADDRESS				CITY		STATE		ZIP		
HOME PHONE		CELL PHONE				WORK PHONE			FAX	

NEXT OF KIN #3						RELATIONSHIP		EMAIL		
ADDRESS				CITY		STATE		ZIP		
HOME PHONE		CELL PHONE				WORK PHONE			FAX	

RESPONSIBLE FOR ACCOUNT						RELATIONSHIP		EMAIL		
ADDRESS				CITY		STATE		ZIP		
HOME PHONE		CELL PHONE				WORK PHONE			FAX	