



Admitting Record

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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							