

THE WILLIAM H. DUNLAP RETIREMENT CENTER, INC.
1495 DUNLAP ORPHANAGE ROAD
BRIGHTON, TN 38011
(901)476-7014

Application For Admission Part 1
Personal Information

NOTE: Please answer all questions as completely and accurately as possible. If adequate space has not been provided, use the back of the page or another sheet. (Also, note Part II, MEDICAL CERTIFICATE) All information will be held in strictist confidence.

Date of Application: _____
Full Name _____ Social Security No. _____
Present Street _____ City _____
Address: State _____ Zip Code _____ Phone _____
With Whom do you live? _____
Date of Birth: Month _____ Day _____ Year _____ Place _____
Present Age _____ Medicare #: _____
TennCare Provider and #: _____
Other Health Insurance Provider: _____
Provider Street _____ City _____
Address: State _____ Zip Code _____ Phone _____
Drug Prescription Card: yes _____ no _____

Physician: Name _____ Phone _____
City _____ State _____

Current Pharmacy: _____ Phone _____

Hospital Preference: _____
Assisted Living Facility Preference: _____
Nursing Home Preference: _____

If non-emergency medical treatment is deemed necessary by Dunlap staff, family will be notified of resident's condition.



If emergency medical treatment is deemed necessary by Dunlap staff 911 will be called. The ambulance service transports our residents to Baptist-Tipton. Family will be notified as soon as emergency services have been contacted.

Other Emergency Instructions: _____

Sex _____ Married _____ Widowed _____ Single _____ Divorced _____
Are you a U.S. Citizen? _____ If not, explain: _____
Veteran Status and Number _____
Name of Spouse: _____
Address, If Living _____
Place of Burial if Deceased _____ Date Deceased _____

How did you hear about Dunlap Retirement Center?

List persons responsible for your care beginning with first person to contact & so on:

Name _____ Occupation _____
Address _____ Relationship _____
Home Phone _____ Work Phone _____

Name _____ Occupation _____

Address _____ Relationship _____

Home Phone _____ Work Phone _____

Name _____ Occupation _____

Address _____ Relationship _____

Home Phone _____ Work Phone _____

Name _____ Occupation _____

Address _____ Relationship _____

Home Phone _____ Work Phone _____

Name _____ Occupation _____

Address _____ Relationship _____

Home Phone _____ Work Phone _____

List any other persons you may want us to notify of special events at the facility.

Names:

Addresses:

Name of your Church: _____

Denomination: _____ Address: _____

Minister _____ Address: _____

Comments: _____

Hobbies: _____

Your Profession, Trade or Occupation _____ Retired ___ Active ___

Will you need a parking space for a car? Yes ___ No ___

Will you be able to participate in activities away from the facility? Yes ___ No ___

Are you able to go about without assistance?

Do you use a cane, crutches, etc.? _____ If yes, Explain _____

Can you attend to all of your normal personal needs? _____

Do you have a guardian? _____ Have you ever been treated for a nervous breakdown or mental illness, either in a hospital or elsewhere? _____

If yes, give full particulars _____

Check any of the following conditions that you now have:

Heart Trouble ___ Epilepsy ___ Cancer ___ Sores ___ Tuberculosis ___ Diabetes ___

High Blood Pressure ___

DATE _____ SIGNATURE _____

PLEASE DO NOT WRITE IN THIS SPACE

Medical Certificate Approved: Yes ___ No ___

Personal Information Approved: Yes ___ No ___

Applicant Approved for Admission:

Date _____

Comment _____

Signature for Admissions Director _____

Occupancy Date _____ Departure Date _____

Reason for Departure _____