



# Telephone Reassurance Program

## Client Information Form

PO Box 2947 • Del Mar, CA 92014 • 858-792-7565

Today's Date \_\_\_\_\_  
Name \_\_\_\_\_ Social Security # (Last 4 Digits) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Phone # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  M  F  
Preferred Language \_\_\_\_\_  Single  Married  Divorced  Widowed  
Medicare # \_\_\_\_\_ Secondary/HMO Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_  
Have you filled out a **California Advance Health Care Directive**?  Yes  No  
If yes please include copy. Agent \_\_\_\_\_ Phone # \_\_\_\_\_  
Have you requested a Do Not Resuscitate order?  Yes  No If Yes, enclose.

### In Case of Emergency Notify:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Ph# \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Ph# \_\_\_\_\_  
Clergy Name \_\_\_\_\_ Faith \_\_\_\_\_ Ph# \_\_\_\_\_

### Pet's Information

Pet Name/Type \_\_\_\_\_ Pet Sitter Name \_\_\_\_\_ Ph# \_\_\_\_\_

### Medical Information

Primary Physician \_\_\_\_\_ Ph# \_\_\_\_\_

Secondary Physician \_\_\_\_\_ Ph# \_\_\_\_\_

Hospital Records located at: \_\_\_\_\_ Ph# \_\_\_\_\_

Normal Blood Pressure \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Type \_\_\_\_\_

Drug Allergies (*specify*) \_\_\_\_\_

Food Allergies (*specify*) \_\_\_\_\_

Others (*specify*) \_\_\_\_\_

**What medical problems/physical disabilities do you have?** (for example: heart problems, diabetes, high blood pressure, etc.) \_\_\_\_\_

**Past Surgeries:** (type and date) \_\_\_\_\_

(Continued on other side)

**Do You:**

Wear dentures?

Yes

No

Wear glasses?

Yes

No

Wear contacts?

Yes

No

Wear Hearing Aids

Yes

No

Other aids? \_\_\_\_\_

Use Oxygen?

Yes

No

Dosage \_\_\_\_\_

**Where do you keep your medications?**

**Current Immunizations:**

Call \_\_\_\_\_ for recommended immunizations.

**Current Medication:** (All Prescription and Over-The-Counter Drugs, Vitamins, and Herbal Supplements)

Name: \_\_\_\_\_ Dosage/Time \_\_\_\_\_ Purpose \_\_\_\_\_

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Name: \_\_\_\_\_ Dosage/Time \_\_\_\_\_ Purpose \_\_\_\_\_

Name: \_\_\_\_\_ Dosage/Time \_\_\_\_\_ Purpose \_\_\_\_\_

**Please Print Clearly**