Pre-Admission Form

MACCLENNY NURSING & REHAB CENTER

If you have any questions or need any assistance, please call our admission staff at 904-259-4873.

Demographic Information

Name of Patient:	Birthdate:	Age:

❒ Male ❒ Female	Is Patient a U.S. Citizen?	❒ Yes ❒ No

Where has the patient been in the last 60 days?

❒ Home ❒ ALF ❒ Hospital ❒ SNF ❒ Other:

Patient's Social Security Number:	

Financial Information

❒ Medicare ❒ Private Pay
❒ Insurance ❒ Medicaid

Name of Insurance:	Medicaid Number:

Insurance Policy Number:	

Reason for Skilled Nursing Facility Placement

❒ Short term stay for therapy from hospital ❒ Long term stay for general care from hospital
❒ Short term stay for therapy from home ❒ Long term stay for general care from home

Last date admitted to hospital:	Last date discharged from hospital:

Current diagnosis or reason for hospitalization:

Contact Information

Name:	
Relationship to Patient:	❒ Self ❒ Daughter ❒ Son ❒ Granddaughter ❒ Grandson

❒ Niece ❒ Nephew ❒ Friend ❒ Other:

Phone:	
Responsible Party:	❒ POA ❒ Health Care Proxy ❒ Health Care Surrogate

❒ Guardian ❒ Other: