Pre-Admission Form

If you have any questions or need any assistance, please call our admission staff at 850-674-5464.

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: