

Name and address of present physician: _____

Will this physician continue your care if you are admitted? _____ Yes _____ No

If not, who will? Physician's name and address: _____

Do you have any specialist physicians? If so, who? _____

Hospital preference: _____ Ambulance preference: _____

Please give dates and nature of any major illnesses or operations you have experienced: _____

Have you been seen within the last two (2) years by an ophthalmologist or an optometrist for vision testing? _____

If yes, please state who and when: _____

Have you ever lived in a place like Hughes Health and Rehabilitation before? _____ Yes _____ No

If yes, please state where and when: _____ from _____ to _____

Have you ever been treated for any nervous or emotional disorder? _____

If yes, please state where and when: _____ from _____ to _____

Have you ever been treated for: Alcohol abuse _____ Drug abuse _____ Other _____

If yes, please state where and when: _____ from _____ to _____

Can you completely care for yourself without assistance? _____ Yes _____ No _____

If not, in what way do you need assistance? _____

Medicaid number: _____ Worker's name: _____

Medicare number: _____ *Part A* _____ *Part B* _____

Med D company: _____ Med D ID number: _____

Blue Cross number: _____ Other insurance: _____

Other insurance:	_____	_____
	Name	Number

Do you own a Connecticut Partnership for Long-Term Care approved insurance policy? _____

How were you referred to Hughes Health and Rehabilitation, Inc.? _____

Name of person responsible for the account: _____

Mail bills to: _____

Address: _____

Phone: _____ (H) _____ (W) _____ (Cell)

Other remarks: _____