



900 South A Street • Richmond, IN 47374

The Elegant Retirement Community

Phone (765) 939-6500 • Fax (765) 965-6833

1. GENERAL INFORMATION

Name: \_\_\_\_\_ Marital Status \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

Medicare #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Spouses Name: \_\_\_\_\_

Spouses Medicare #: \_\_\_\_\_ Spouses Social Security #: \_\_\_\_\_

Other Insurance: \_\_\_\_\_

Church Attended: \_\_\_\_\_

2. MEDICAL INFORMATION

Date & Place of Birth: \_\_\_\_\_

Male  Female  (month / day / year) (City / State)

Spouses Date & Place of Birth: \_\_\_\_\_

Male  Female  (month / day / year) (City / State)

Name of Physician: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

Physician #2 \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

Special Orders/Diet: \_\_\_\_\_

Do you or your spouse have any health problems which may prevent you from participating in any recreational activities? Please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hospitalization in the past 12 months? YES  NO  If yes, list hospital, reason, term, and attending physician:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Spouse Hospitalization in the past 12 months? YES  NO  If yes, list hospital, reason, term, and attending physician:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_