New Resident Face Sheet

Date_____Name of Facility_____Wing/Unit_____

Resident's Name_____ Date of Birth_____ Sex: M or F

Admit Date_____Prescriber's Name_____

Allergies_____ Diagnosis_____

PAYOR SOURCE

☐**Medicare A/ SNF** ☐**Managed Care/HMO** ☐**MaineCare** ☐**Private Pay/Insurance**

Medicare#_____Medicaid#_____Soc Sec#_____

Insurance coverage**_____ID #_____

RX Group #_____ RX BIN#_____PCN#_____

****If you have Insurance drug card, please FAX clear copies-both sides of card****

Financial POA Name_____

Address_____

Phone # _____Email_____

Medical POA Name_____

Address_____

Phone #_____ Email_____

Name of Person Completing This form: _____

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