TransCare
Mobile Health Service

160 West Street, Milford MA 01757
Phone: 508-473-CARE (2273)
Fax: 508-473-2275

Resident and Guarantor Information Sheet

Resident Information:

Name: _____ Date of Birth: _____

Apt. #: _____ SSN: _____

Phone #: _____ Cell Phone #: _____

Insurance Information:

Primary Insurance Carrier: _____

Insurance I.D. #: _____ Group #: _____

Insurance Address as listed on card: _____

_____

Secondary Insurance Carrier: _____

Insurance I.D. #: _____ Group #: _____

Insurance Address as listed on card: _____

_____

_____ Resident is self - guarantor.

_____ Health Care Proxy (HCP) or Power of Attorney(POA) is invoked. (See info below)

_____ Another party is financially responsible for resident's medical care. (See info below)

Responsible Party/Guarantor Information (If different from resident):

Name: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Address: _____

Email Address: _____

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RESIDENT HEALTH & MEDICATION HISTORY

Resident Name: _____ **Date of Birth:** _____ **Room #:** _____

Medical History: *(check if you had or have any of the following)*

___Diabetes ___Type 1 ___Type 2 ___Controlled ___Uncontrolled
___Hypertension (High Blood Pressure) ___Tuberculosis ___Asthma ___Kidney Disease
___Bleeding/Clotting Disorders ___Rheumatic Fever ___Anemia ___Gout
___PVD (Circulation Disease) ___Arthritis ___Cancer ___Epilepsy
___Heart Disease ___Other(s):_____
___High Cholesterol _____

Past Surgical History: *(Please include date of surgery):*

_____
_____
_____

Medications & Allergies:

Current Medications: (Including Non-Prescription and Herbal Medications you are currently taking)

_____
_____
_____
_____
_____
_____

Allergies: *(Please list any known allergies and reactions)*

____No Known Allergies
___Local Anesthetic:_____
___Sulfa: _____
___IV Dye: _____
___Tape:_____
___Penicillin: _____
___Iodine: _____
___Aspirin:_____
___Latex: _____
___Other: _____

I certify this information is true and correct to the best of my knowledge. I will notify you on any changes in my status or the above information.

Signature: _____ **Date:** _____

Relationship to Resident: _____