

Wesley Village

2800 Loy Lake Rd. Denison, TX 75020

903-465-6463 Fax 903-465-6498

APPLICATION FOR ADMISSION

Independent Living Assisted Living

Date _____

Name _____ Medicare Number _____

Present Address _____ Phone _____

Date of Birth _____ Place of Birth _____ Gender _____

Marital Status: Single Married Separated Divorced Widowed

Past Occupation (s) _____ Social Security # _____

Spouse's Name _____ Social Security # _____

If deceased, Date of Death _____

Names and addresses of living children; if none live in the Texoma area, please list close friends or relatives who live in the Texoma area.

Name Address Relationship 10 digit phone #

Name	Address	Relationship	10 digit phone #

Have you ever been a resident in another Retirement Community, an Assisted Living, Nursing facility or another similar facility? Yes No

If yes, name of facility: _____

Address _____

Reason for leaving: _____

Have you ever been a patient or resident of a state, government, or private mental or psychiatric hospital or institution? Yes No If so, where and when? _____

Name all serious illnesses, surgical operations, x-ray or radiation therapy that you have had and give dates:

Describe any serious injuries that you have had and give dates: _____

Please specify any deformities or physical limitations that you have: _____

Do you tire easily? Yes No Are you sensitive to heat or cold? Yes No

Are you subject to dizziness, faintness, or recurring headaches? Yes No

Are you able to attend the dining room? Yes No

Do you have specific dietary restrictions or requirements? Yes No

If so, discuss them: _____

Can you manage any special requirements by making appropriate choices of menu items? Yes No

Do you have eye problems? Yes No Do they present mobility problems? Yes No

Do you wear glasses? Yes No Do you wear contacts? Yes No

Do you have implants? Yes No

What is your corrected vision? _____/_____ If numbers not known, describe in words:

Describe your hearing status: _____

Do you have dentures? Yes No How is your dental situation? _____

Do you suffer from hay fever, asthma, other breathing allergies or problems? Yes No

Describe _____

Have you ever had a goiter or been under treatment for a thyroid condition? Yes No

Describe _____

How did the thyroid condition affect your general health? _____

Do you have, or have you had heart problems? Yes No Blood pressure problems? Yes No

If so, describe; _____

Have you had tuberculosis, pneumonia, or other lung diseases? Yes No

Describe _____

How is your breathing at present? _____ Do you use oxygen? Yes No

Do you have digestive problems? Yes No Describe _____

Please describe any weight changes in the past few years: _____

What kidney or bladder condition have you had, or now have? _____

Do you have any form of arthritis or other joint, bone or muscle trouble? Yes No

Describe _____

How does it affect and restrict you? _____

Have you ever had anemia? Yes No Describe _____

What treatment for it did or do you receive? _____

Have you ever had a partial or complete nervous breakdown? Yes No

Describe _____

Have you ever had any strokes? Yes No

Describe _____

Are you under medical care at the present time? Yes No

If so, for what? _____

Please list all the medicines, prescription and non-prescription, that you are now taking.

Please give the name and addresses of physicians that you have seen in the last three years.

So far as you know, have any of your relatives had any of the following conditions or illnesses? If so, specify the relationship by the name of the illness.

Diabetes _____

Cancer _____

Heart Disease _____

High Blood Pressure _____

Arthritis _____

Mental illness _____

The above information is complete, true, and correct to the best of my knowledge

Signature of Applicant

Date

Signature of Responsible Party