

# LINCOLN HILL MANOR

53 Lincoln Street Spencer MA 01562  
(508) 885-3338

## Identification and Summary Sheet

Name \_\_\_\_\_ Nick Name \_\_\_\_\_

Address \_\_\_\_\_ Race \_\_\_\_\_  
(Street) (Town/City) (State/ZIP)

Sex \_\_\_\_\_ Date of Admission \_\_\_\_/\_\_\_\_/\_\_\_\_ Time of Admission \_\_\_\_:\_\_\_\_ AM/PM Room # \_\_\_\_\_

SSN# \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of Birth \_\_\_\_\_

Marital State M\_\_\_S\_\_\_W\_\_\_ Sep\_\_\_D\_\_\_ Religion \_\_\_\_\_ Church \_\_\_\_\_

Admitting Diagnosis \_\_\_\_\_

Medicare No. \_\_\_\_\_ Other Insurance (Name) \_\_\_\_\_ No. \_\_\_\_\_

Attending Physician \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

Other Practitioner \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

Other Practitioner \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

Referring Agency/Physician \_\_\_\_\_

Address \_\_\_\_\_

Health Care Proxy Completed Y/N DNR Y/N

Next of Kin \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_  
(Street) (Town/City) (State/ZIP)

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(Street) (Town/City) (State/ZIP)