WELLNESS ADULT DAY SERVICES

Participant Application

First Name: __________________________ Last Name: __________________ Date: ____________

Birth Date: ____________ Birth Place: ____________________ Age: __________ Gender: ______

Current Address: ____

Telephone: _________________________ Language Speak at Home: _______________________

Medical Insurance Name: ______________________________ ID # _________________________

Emergency Contact Person:

1. Name: ____ Telephone: _________________

   Relationship to Participant: ____

   Address: ____

2. Name: ____ Telephone: _________________

   Relationship to Participant: ____

   Address: ____

Referral Organization:

Referral Organization Name: ________________________________Telephone: _______________

Address: ____

Social Worker/Care Coordinator Name: _______________________ Telephone: ______________

Reason for Referral: ____

Medical Information:

Primary Physician Name: ____

Clinic Name: ____ Telephone: ___________

Clinic Address: ____

Pharmacy Name: ____ Telephone: ___________

Pharmacy Address: ____

Hospital Name: ____ Telephone: ___________

Hospital Contact Person if applicable: ____

Hospital Address: ____

Allergies to Medication:

1.
2.
3.

Allergies to Food:

1.
2.
3.

Please list others health issue if any:

❖ **If an emergency medical care becomes necessary, I give permission for any treatment that the physician deems necessary.**

X____ Date: ___________________

Signature of Participant or Responsible Party

WELLNESS ADULT DAY SERVICES
AUTHORIZATION FOR RELEASE OF INFORMATION

First Name: __________________________ Last Name: __________________ Date: ____________

Birth Date: ____________ Birth Place: ____________________ Age: _________ Gender: ______

Current Address: ____

This will authorize:
Primary Physician Name: ____

Clinic Name: ____ Telephone: ____________

Clinic Address: ____

To release information from the medical records maintained while I am/was a patient/participant at this Adult Day Services.

Wellness Adult Day Services **689 Dale Street, North** **Saint Paul, MN 55103** **Tel: 651-528-7557 Fax: 651-528-7255**

The information to be disclosed are:

Prescribed Diets: _____

Current Medications: _____

Others (please specify): ____

X____ Date: __________________
Signature of Participant or Responsible Party