**ADMISSION APPLICATION**

MARIAN MANOR HEALTHCARE CENTER
PO BOX 578
604 ASH AVE EAST
GLEN ULLIN,NORTH DAKOTA 58631
PHONE 701-348-3107
www.marianmanorhc.com

Date_____
Applicant's Name_____
Address_____
Age_____Birthdate_____Place of Birth_____
Citizenship_____
Marital Status:_____Social Security No_____
Medicare No,_____Medicaid No._____
Health Insurance No._____
Name of Spouse if living_____Religion_____
Did applicant receive health services at home: ( ) Yes ( ) No
If yes, from whom?_____
Physician_____Hospital_____
Pharmacy_____Dentist_____
Optometrist_____
Applicant's Physical Condition: ( ) Bedfast ( ) Ambulatory
Explain:_____
Describe Physical Problems:_____
_____
Applicant's Mental Condition:
( ) Clear ( ) Confused ( ) Combative\
( ) Wandering ( ) Cooperative
Explain:_____
Diagnosis:_____
Medications:_____
_____
Name,Address and Telephone Numbers of Children/Next of Kin:
_____
_____
_____
_____
Source of Payment: ( ) Private Funds ( ) County Assistance
Nursing Home Insurance_____
Name of Company_____
Person responsible for payment:_____
Address_____
Telephone_____
Person to be contacted in regard to this application:
_____
Address:_____
Telephone_____