Oakridge Gardens
REHABILITATION & MEMORY CENTER
1700 Midway Road, Menasha, WI 54952 • 920-739-0111

APPLICATION FOR ADMISSION

**** ALL INSURANCE CARDS NEEDED AT TIME OF ADMISSION****

Please return this completed form to the Admissions Director or the Business Office. All information will be held in strict confidence. If you have any questions please call us at (920) 739-0111.

Name: _____
First Middle Last Maiden

Address: _____
Street City State Zip Code

Phone: _____ **Preferred Name:** _____ **Occupation:** _____

Marital Status: Married ____ **Never Married** ____ **Widowed** ____ **Divorced** ____

Race (check all that apply): American Indian/Alaska_____ Asian _____ Black/African American ____
Hispanic/Latino_____ Native Hawaiian/other Pacific Islander _____ White_____

Present Age:_____ **Date of Birth:** _____ **Sex: Male** _____ **Female** _____

Social Security #: _____ **(copy of card required)**

Medicare A plan #: _____ **(copy of original Medicare Card required)**

Alternate Medicare Plan: _____ **(copy of card required)**
company name ID number

Supplement Insurance: _____ **(copy of card required)**
company name ID number group number

Medicaid (M.A.) #: _____ **(copy of card required)**

Are you enrolled in Family Care? _____

Name of Spouse: _____ **Spouses Address:** _____

Denomination:_____ **Church:** _____

Address: _____

Hospital Preference: Appleton Medical Center St. Elizabeth's Theda Clark

Primary Physician: _____

Funeral Home: _____ **City:** _____

WHO TO NOTIFY IN CASE OF AN EMERGENCY – PLEASE LIST TWO IN ORDER OF PRIORITY

1. Name: _____ Relationship: _____

Address: _____ Phone # Home: _____

_____ Work: _____

Cell : _____

2. Name: _____ Relationship: _____

Address: _____ Phone # Home: _____

_____ Work: _____

Cell: _____

BILLING INFORMATION:

Do you have a prepaid Burial Fund? Yes _____ No _____

Do you have a Long-term Care Insurance Policy? Yes_____ No____

If yes: name of company: _____

Policy Number: _____

To whom should the bill be sent: Name:_____

Address: _____

_____

Phone: _____

Do you have a family Attorney? Yes_____ No _____ Name: _____

Is there a Power of Attorney for Health Care? _____ If yes, has it been activated by two physicians? Yes ____ No ____(Copy will be needed upon admission).

Please check if you have any of the following:
Power of Attorney for Finance: _____ Conservator: _____ Legal Guardian: _____
If yes: Name: _____

Address: _____

_____

Phone #: _____

FINANCIAL INFORMATION:

Cash in banks:

Institution:	Owner	Account Number	Checking/Savings/ CD/Money Mkt.	Current Balances

Securities/Real Estate:

Description	Owner	Restricted/Pledged	Current Mkt. Value	If Real Estate, Mortgage Amount

Monthly Income: (i.e. social security, pension, other)

Type:	Amount:

By your signature below, you authorize Oakridge Gardens Nursing Center, Inc. to verify the above information and that the information is true, complete and correct as of the date of signing.

Signature of the person completing this form: _____

Date: _____

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