THE PINES
AT • DAVIDSON

APPLICATION FOR ADMISSION

Full Name: ______________________ Spouse's Name: ______________________

Address: ____

____

Email: ______________________ Telephone #: ______________________

Social Security Number: ______________ Date of Birth: ____________ Place of Birth: ______________

❑ Male ❑ Female | ❑ Married ❑ Widow ❑ Separated ❑ Single | Years at Present Address: ______ ❑ Rent ❑ Own

Where have you lived most of your life? ____

Have you at any time been a resident of another retirement community? ❑ No ❑ Yes, how many years? _________

Name: ______________________ Address: ______________________

Background:

Education Background: ____

In what vocations or professions are/or were you engaged? ______________________________

____

____

____

In what volunteer community services are/or were you engaged? ______________________________

____

What are your special interests, hobbies, or skills? ______________________________

____

Please List Your Children:

	Name:	Address:	Telephone #:
1.			
2.			
3.			
4.			

Please List Other Close Relatives:

Name: Address: Telephone #:

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

Religion:

Present church affiliation (Church Name): ______________________________

Church Address: ______________________________

Denomination: ____________________ Pastor's Name: ____________________

Do you presently have a person or firm handling your business affairs?:

❑ No ❑ Yes, please name:

Address: ______________________________

Telephone #: ______________________________

Who is the executor of your estate or will?

Name: ______________________________

Address: ______________________________

Telephone #: ______________________________

Signature: ______________________________

Date: ______________________________

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PERSONAL HEALTH HISTORY

In your own words, briefly describe your health: ______________________________

____

____

______________________________ Height: ________ Weight: ________

Specify any limitations you have (vision, hearing, climbing steps, driving, walker, wheelchair, etc.):

____

____

Describe any allergies including reactions to any drugs/medications:

____

____

Describe major surgical operations, serious illness, or hospitalizations (include approximate year):

1. Year: ________ ______________________________

2. Year: ________ ______________________________

3. Year: ________ ______________________________

Are you presently under special medical care?: ❑ No ❑ Yes, describe: ______________________________

____

Have you ever been treated for depression, anxiety, or any other mental disorders?: ❑ No ❑ Yes, describe: ______________________________

____

Do you have or have you had the following:

Tuberculosis ❑ Yes ❑ No		Polio ❑ Yes ❑ No		Heart Attack or Heart Disease ❑ Yes ❑ No	
Cancer ❑ Yes ❑ No		Paralysis ❑ Yes ❑ No		Alcoholism or Drug Addition ❑ Yes ❑ No	
Stroke ❑ Yes ❑ No		Anemia ❑ Yes ❑ No		Nervous Breakdown or Psychiatric Care ❑ Yes ❑ No	
Asthma ❑ Yes ❑ No		Kidney Disease ❑ Yes ❑ No			
Diabetes ❑ Yes ❑ No		Hernia ❑ Yes ❑ No			
Rheumatism ❑ Yes ❑ No		Epilepsy ❑ Yes ❑ No			

Fractures ❑ Yes ❑ No If yes, what bones? ______________________________

Do you have special diet?: ❑ No ❑ Yes, describe: ____________________

____

Preferred Hospital: ____________________

City/State/Zip: ____________________

Medicare Supplement Insurance: ____________________

Long-Term (Nursing) Care Insurance: ____________________ Daily Benefit $______ Years____ Annual Premium $_______

Medicare Number: ____________________

Do you receive other supplemental insurance?: ❑ No ❑ Yes, describe: ____________________

____

Physician(s):

1. Name: ____________________

   Address: ____________________ Telephone # ____________________

2. Name: ____________________

   Address: ____________________ Telephone # ____________________

Dentist(s):

Name: ____________________

Address: ____________________ Telephone #: ____________________

In Case of Emergency, notify:

1. Name: ____________________

   Relationship: ____________________ Telephone #: ____________________

   Address: ____________________

Additional Remarks or Clarifications:

____

____

____

____

I declare the answers to be true, full and complete.

Signature: ____________________

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CONFIDENTIAL FINANCIAL STATEMENT

Full Name: ______________________DOB:__________ Spouse's Name: ______________________DOB:__________

Address:____

Email: ____ Telephone:__________________________________

ASSETS	TOTAL	LIABILITIES	TOTAL
Cash on Hand & in Banks	$	Notes Payable to Banks	$
U.S. Government Securities (Treasury Bills, Bonds, etc.)	$	Notes Payable to Others	$
Listed Securities (Stocks, Mutual Funds, etc.)	$	Accounts Due	$
Unlisted Securities (Private Investments, etc.)	$	Long Term Care Annual Premium	$
Accounts & Notes Receivable	$	Real Estate Mortgages Payable (See Schedule on Back.)	$
Real Estate Owned (See Schedule on Back)	$	Other Debts (Itemize)	$
Life Insurance, Cash Value	$		
Automobiles	$		
Personal Property	$		
Certificates of Deposit	$		
Other Assets (Itemize)	$		
Annuity Value	$		
Trust			
TOTAL ASSETS	**$**	**TOTAL LIABILITIES**	**$**
		NET WORTH (Total Assets minus Total Liabilities)	**$**

INITIAL HERE __________ The total principal of all investments shown above will be available to meet my financial/healthcare obligations until my death.

Schedule of U.S. Government Securities, Listed & Unlisted Securities, Other Stocks & Bonds Owned

No. Of Shares/Bonds	Description	In name of	Market Value
(If more space needed, please attach information)			

Schedule of Real Estate Owned

Description of Property & Improvement	Date Acquired	Title in Name of	Cost	Market Value	Mortgage Amount	Terms
			$	$	$	

Schedule of Notes Payable

Name of Creditor	Original Amount	Unpaid Balance	Payment Terms	Collateral-Endorser
	$	$		

Schedule of Life Insurance Carried, Including Group Insurance, Long Term Care

Amount	Name of Company	Beneficiary	Cash Surrender Value	Loan Amount
$			$	$

ANNUAL INCOME	TOTAL
Name	$
Annuity Term:	$
Pension:	$
Dividend:	$
Interest:	$
Real Estate Income:	$
Trust:	$
Other Income (specify)	$
TOTAL	**$**

Name of person having power-of-attorney over my affairs:

____

City: ______________________ State: ______________

Telephone #: ______________________________

I affirm that this information is correct & substantially complete to the best of my knowledge.

Signature: ______________________________

Spouse: ______________________________

Date: ______________________________