Service Caring Commitment

Strasburg Care Center
409 S. 3rd Street • Strasburg ND 58573
701-336-2651 • 336-7558 (fax) • scc@bektel.com

STRASBURG CARE CENTER APPLICATION FOR ADMISSION

RESIDENT INFORMATION:

Name:_____ Date of Birth: _____ Age: _____

Address: _____ County: _____ Phone: _____

Religion:_____ Marital Status: S M W D

Birth Place: _____ Social Security Number: _____

Medicare #_____ Medicaid # _____

Health Insurance Co. _____ Policy # _____

Long Term Care Insurance Co. _____ Policy # _____

Medicare Prescription Drug Plan Co. _____ Policy #: _____

IN CASE OF EMERGENCY NOTIFY:

Name: _____ Relationship: _____

Home Phone # _____Work Ph. # _____ Cell Phone # _____

Address: _____

Name: _____ Relationship: _____

Home Phone # _____Work Ph. # _____ Cell Phone # _____

Address: _____

RESPONSIBLE PARTY:

Name: _____ Relationship: _____

MORTUARY:

Name: _____ Phone No. & Address: _____

CHOICE OF PHARMACY:

Name: _____ Phone No. & Address: _____

_____

Signature (Applicant or Responsible Party) **Date**