FACE SHEET

Name:_____

DOB: _____ Sex:_____

Eye Color:_____ Hair Color:_____

Vision:_____ Hearing:_____

HT:_____ WT:_____

Date Admitted:_____ Ambulatory: Yes____ No____

_____ Medi-Cal #:_____

SSI #:_____

Current Residence:_____

_____

Diagnosis:_____

Special Health Conditions/Problems (include seizure type, frequency, and duration):_____

_____

Tetanus Date:_____ Allergies (food, drugs, other):_____

T.B. Date:_____ Results:_____

Primary M.D.:_____ Phone:_____

Address:_____

Primary Dentist:_____ Phone:_____

Address:_____

Other:_____ Phone:_____

Legal Status: Has consumer been appointed a conservator (for adults) or guardian (for minors): Yes_____ No_____

Parent/Guardian/Conservator

Name:_____

Address:_____

City/State/Zip:_____

Home Phone:_____ Work Phone:_____

Nearest Relative/Emergency Contact

Name:_____

Address:_____

City/State/Zip:_____

Home Phone:_____ Work Phone:_____

Case Worker:_____ Agency:_____

Address:_____ City/State/Zip:_____

Phone:_____

Day Program:_____

Address:_____ City/State/Zip:_____

Phone:_____