**Client Face Sheet**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client Name**: | | | | | **DOB**: | | | | | | | **SS#**: | | | |
| **Admission Date**: | | | | **Phone Number**: | | | | | | **Address**: | | | | | |
| **Advance Directives**: Full Code DNR N/A | | | | | | | | | | | | | | | |
| **Primary Diagnosis**: | | | | | | **Known Allergies**: | | | | | | | **Preferred Hospital**: | | |
| **Physician Name**: | | **Physician Phone**: | | | | | | **Pharmacy Name**: | | | | | | **Pharmacy Phone**: | |
| **POA Name**: | | | | | | | | **POA Phone**: | | | | | | | |
| **Marital Status**:  Single  Married  Separated/Divorced  Widowed - How long? | | | | | | | | | | | | | | | |
| **Lives:**  Alone  With: | | | Primary Language: | | | | | | Other Language: | | | | | | Religion: |
| **In Case of an Emergency Contact:** | | | | | | | | | | | | | | | |
| **Primary Contact** | *Check if same as POA* | | | | | | **Secondary Contact** | | | |  | | | | |
| Relationship to Client |  | | | | | | Relationship to Client | | | |  | | | | |
| Home Phone # |  | | | | | | Home # | | | |  | | | | |
| Work Phone # |  | | | | | | Work Phone # | | | |  | | | | |
| Cell # |  | | | | | | Cell # | | | |  | | | | |
| E-mail: |  | | | | | | E-mail: | | | |  | | | | |
| Address |  | | | | | | Address | | | |  | | | | |
| City/State/Zip |  | | | | | | City/State/Zip | | | |  | | | | |
| Other Information: | | | | | | | | | | | | | | | |