GALEON ASSISTED LIVING
410 West Main Street
Osakis, MN 56360
320-859-2142 Fax 320-859-6293

TENANT INFORMATION SHEET

Tenant Name:_____ ID #:_____ Admission Date:_____
Apt. #:_____ Age:_____ D.O.B.:_____ Sex: M F Religion:_____
SSN:_____-_____-_____ Marital Status: M S W D Telephone #:_____

Responsible Party: _____Relationship:_____
Address:_____Telephone:_____
City:_____ State_____ Zip_____

Hospital Preference:_____
Insurance Carrier:_____ Policy #:_____
Medicare #:_____Medical Assistance #:_____
Funeral Home Preference:_____

Primary Physician:_____Telephone_____-_____-_____
Address:_____City:_____Zip:_____
Pharmacy Preference:_____Telephone_____-_____-_____
Address:_____City:_____Zip:_____
Psychiatrist:_____Telephone_____-_____-_____
Address:_____City:_____Zip:_____
Dentist:_____Telephone_____-_____-_____
Address:_____City:_____Zip:_____
Eye Physician:_____Telephone_____-_____-_____
Address:_____City:_____Zip:_____
Podiatrist:_____Telephone_____-_____-_____
Address:_____City:_____Zip:_____

OTHER HEALTHCARE PROVIDERS/HOME CARE PROVIDERS
Name:_____Telephone_____-_____-_____
Address:_____City:_____Zip:_____
Name:_____Telephone_____-_____-_____
Address:_____City:_____Zip:_____

Allergies:_____

Information Current as of: _____/_____/_____

EMERGENCY NOTIFICATION

Medical Emergency Contact #1)

Name:_____Relationship:_____ Phone(H)_____-_____-_____
Address:_____Phone(C)_____-_____-_____

Alternates:
Name:_____Relationship:_____ Phone(H)_____-_____-_____
Address:_____Phone(C)_____-_____-_____

Name:_____Relationship:_____ Phone(H)_____-_____-_____
Address:_____Phone(C)_____-_____-_____

Tenant Name: _____