Marion Somers, Ph.D.

www.DoctorMarion.com

Please type or print

Date

Client (Patient or Resident)

Date of Birth:	
Age Now:	
Social Security #	
Medicare #	
Medicaid #	
Chart #	

Name: _____

Home Address:

APT #:

Cross Streets:

Parking:

Alternate Parking: _____
Parking Restrictions: _____
Hours: _____

Travel Directions:

Map Info: _____

Public Transportation:

Telephone #

Home:	Business:	Cell:
Home Fax:	Business Fax:	Beeper:
E-Mail:	Business E-mail:	

Hospital or Nursing Facility

Name: _____

Address:

Building: _____
Floor: _____
Room: _____

Cross Streets:

Parking:

Travel Directions:

Public Transportation:

Telephone #

Business:	Fax:	Website:
Cell:	Beeper:	E-Mail:

Does Client have (please check all that apply):

_____ A Will
_____ Health Care Proxy
_____ Durable Power of Attorney (survives incapacity) - guardian
_____ DNR (Do Not Resuscitate)
_____ Patient Review Instrument (PRI)

Other advanced directives.
List:

Referred to Dr. Marion Somers by: _____

Primary Contact Person

Name: _____ Relationship: _____

Address:

Telephone #

Home:	Business:	Cell:

Home Fax: Business Fax: Beeper:
E-Mail: Business E-mail:

Billing Person (if Different)

Name: Relationship:

Address:

Telephone #
Home: Business: Cell:
Home Fax: Business Fax: Beeper:
E-Mail: Business E-mail:

Aide or Nurse (there may be several)

What Shift:

	Days	Hours
Name:	Monday:	
	Tuesday:	
Address:	Wednesday:	
	Thursday:	
	Friday:	
	Saturday:	
	Sunday:	

Telephone #
Home: Business: Fax:
Cell: Beeper: E-Mail:

Agency Name:
Address: Website:
Business tel: Fax: E-Mail:

Aide or Nurse

What Shift:

	Days	Hours
Name:	Monday:	
	Tuesday:	
Address:	Wednesday:	
	Thursday:	
	Friday:	
	Saturday:	
	Sunday:	

Telephone #
Home: Business: Fax:
Cell: Beeper: E-Mail:

Agency Name:
Address: Website:
Business tel: Fax: E-Mail:

Doctors

Name: Specialty:
Address: Emergency Tel #
Hospital Tel #

Telephone #
Home: Business: Fax:
Cell: Beeper: E-Mail:

Name: Specialty:
Address: Emergency Tel #
Hospital Tel #

Telephone #
Home: Business: Fax:
Cell: Beeper: E-Mail:

Name: ________________ Specialty: ________________

Address: Emergency Tel # ________________

Hospital Tel # ________________

Telephone #

Home: Business: Fax:

Cell: Beeper: E-Mail:

Name: ________________ Specialty: ________________

Address: Emergency Tel # ________________

Hospital Tel # ________________

Telephone #

Home: Business: Fax:

Cell: Beeper: E-Mail:

Name: ________________ Specialty: ________________

Address: Emergency Tel # ________________

Hospital Tel # ________________

Telephone #

Home: Business: Fax:

Cell: Beeper: E-Mail:

Name: ________________ Specialty: ________________

Address: Emergency Tel # ________________

Hospital Tel # ________________

Telephone #

Home: Business: Fax:

Cell: Beeper: E-Mail:

Name: ________________ Specialty: ________________

Address: Emergency Tel # ________________

Hospital Tel # ________________

Telephone #

Home: Business: Fax:

Cell: Beeper: E-Mail:

Dentist

Name: ________________ Specialty: ________________

Address:

Telephone #

Home: Business: Fax:

Cell: Beeper: E-Mail:

Podiatrist

Name: ________________ Specialty: ________________

Address:

Telephone #

Home: Business: Fax:

Cell: Beeper: E-Mail:

Local Pharmacy

Name: ________________

Address:

Telephone #

Home:	Business:	Fax:
Cell:	Beeper:	E-Mail:

Lawyer

Name: _____

Address:

Telephone #

Home:	Business:	Fax:
Cell:	Beeper:	E-Mail:

Accountant/Financial Advisor

Name: _____

Address:

Telephone #

Home:	Business:	Fax:
Cell:	Beeper:	E-Mail:

Others: _____

Who has keys to client's apartment/house?: _____

Other Involved Relatives

_____

Name: _____ Relationship: _____

Address:

Telephone #

Home:	Business:	Fax:
Cell:	Beeper:	E-Mail:

Name: _____ Relationship: _____

Address:

Telephone #

Home:	Business:	Fax:
Cell:	Beeper:	E-Mail:

Name: _____ Relationship: _____

Address:

Telephone #

Home:	Business:	Fax:
Cell:	Beeper:	E-Mail:

Neighbors, Doorman, Superintendent or other involved persons.

Name: _____ Relationship: _____

Address:

Telephone #

Home:	Business:	Fax:
Cell:	Beeper:	E-Mail:

Name: _____ Relationship: _____

Address:

Telephone #

Home:	Business:	Fax:
Cell:	Beeper:	E-Mail:

Name: _____ Relationship: _____

Address:

Telephone #

Home:	Business:	Fax:
Cell:	Beeper:	E-Mail:

Client Needs

Clients Medical Condition/Diagnosis:

Medications:	Dosage:	Times:	Needed for/Condition
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Over the counter drugs, vitamins, herbs: _____

Allergies/Allergic to: _____

Additional information

Country & City of Birth: _____

Mothers Maiden Name: _____

Mothers Full Name: _____

Fathers Full Name: _____

Languages spoken by client:

Now with family: _____
As a child: _____
Siblings 1: _____
2: _____
3: _____
4: _____
5: _____
6:

US Citizen: Yes _____ No. Years: _____ No _____

Came to this country: _____ At age: _____
(year/date)

Car:

Is there a car: Yes _____ No _____
Is client driving? Yes _____ No _____

Who does the driving?: _____

Who has the car keys?: _____

Organizations

Attends Community Center, Social Groups or Volunteers

Name: _____

Address

Religious Affiliation:

Now: _____

Childhood: _____

Religious Organization or place of worship: _____

Address

Telephone #

Business: Fax:

Cell: Beeper: E-Mail:

Burial Information

Family Name or Association: _____

Name: _____ Plot #: _____

Address:

Location information may be under another name or organization:

Contact Name: _____

Telephone #

Business: Fax:

Cell: Beeper: E-Mail:

Military information

Branch of service: _____
Date of enlistment: _____
Date of discharge: _____
Honors or medals: _____
Additional information: _____

Use this page for additional information

Form completed by | Home # | Work #

Thank you for taking the time to fill out this Doctor Marion Client Information Form (CIF).

Marion Somers, Ph.D.
Doctor Marion
www.DoctorMarion.com