

**Highland House**

Assisted Living  
"Caring is the heart of the matter"

710 N Main St  
Highlands, TX 77562  
email: hh710nmain@yahoo.com

Administrator (281) 843-2326  
Manager (832) 428-8100  
Fax (281) 843-3260

**CLIENT PROFILE**

Please fill-out this form and return it to the office or fax it to 281-843-3260

**TODAY'S DATE:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
**ADMIT DATE:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**CLIENT NAME:** \_\_\_\_\_  
**SSN:** \_\_\_\_\_  
**PHONE:** \_\_\_\_\_  
**CURRENT ADDRESS:** \_\_\_\_\_  
**AGE** \_\_\_\_\_ **DOB** \_\_\_\_\_  
**SEX** \_\_\_\_\_ **RACE** \_\_\_\_\_  
**Marital Status:** \_\_\_\_\_  
**CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP** \_\_\_\_\_

S = Single  
M=Married  
W=Widower  
D=Divorced

**PREVIOUS OCCUPATION:** \_\_\_\_\_  
(PRIOR TO RETIREMENT AND/OR DURING MOST OF WORKING LIFE)

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
(For emergency notification)

Known Allergies: \_\_\_\_\_  
(Please state medicines and/or foods)

Client has an "Advanced Directive" for medical care? Yes [ ] No [ ]  
(If client enters into an unconscious state)

Client formally served by a home health service? Yes [ ] No [ ]  
If yes, give Name and \_\_\_\_\_  
Phone Number \_\_\_\_\_

Client takes medication? Yes [ ] No [ ] If yes, please provide a list of all medications taken.  
If yes above, please check dispense preference: Self Dispense [ ] Staff Dispense [ ]  
(If client self dispenses, monthly inventory check by staff is required)

Pharmacy Preference: \_\_\_\_\_ Phone: \_\_\_\_\_

Medicare/Medicaid Number ( If available): \_\_\_\_\_

Mortuary Preference: \_\_\_\_\_ Phone: \_\_\_\_\_

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## CLIENT NAME:

\_\_\_\_\_

(FIRST)

(INITIAL)

(LAST)

## CLIENT REPRESENTATIVE

Representative Name: \_\_\_\_\_

Type: Legal [ ] POA [ ] Relative [ ] Friend [ ]

Current Address: \_\_\_\_\_

\_\_\_\_\_

CITY

STATE

ZIP

Telephone: \_\_\_\_\_

Residence

Employment

## EMERGENCY CONTACTS

Name	Address	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____