SarahCare®
Coral Springs Adult Day Care Center

Intake Assessment

Participants Name & Address

Participant Name: _____ **Birth Date** ____/____/___

Address: _____

Demographics

Place of Birth: _____ **Age:** _____ **Sex:** ☐Male ☐Female

Marital Status: ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Single ☐ Significant Other

Preferred Hospital: _____ **Religion:**_____

Primary Language: _____

Race: ☐ White ☐ Oriental/Asian ☐ African American ☐ Hispanic ☐ Other Ethnic Origin: _____

Primary Caregiver / Emergency Contact

Emergency Contact #1:

Name:_____ Email:_____

Relationship:_____ Cell Phone:_____

Home Phone:_____

Emergency Contact #2:

Name:_____ Cell Phone:_____

Relationship:_____ Home Phone:_____

Emergency Contact #3:

Name:_____ Cell Phone:_____

Relationship:_____ Home Phone:_____

Emergency Contact #4:

Name:_____ Cell Phone:_____

Relationship:_____ Home Phone:_____

Primary Physician and Health Insurance Information

Primary Physician:_____ (Phone) _____ (Fax) _____

Address:_____

Primary Health Insurance:_____ Insurance ID#_____

Secondary Health Insurance:_____ Insurance ID#_____

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