Alzheimer's Service Center
6701 Highway 85, Riverdale, Georgia 30274
(770) 603-4090 Fax (770) 603-4092

CLIENT INFORMATION

Today's Date ____ / ____ / ____

Applicants Name _____ D.O.B. ___/ ____ / ____ Age _____ M [ ] F [ ]

Home Address _____ Appt. # _____

City _____ County _____ Zip Code _____

Telephone # _____ Telephone # _____

Social Security Number ____ / ____ / ____ Medicaid/Medicare # _____

Primary Caretaker _____ Relationship to Applicant _____

Address _____ Appt. # _____
(If different from Applicant)

City _____ County _____ Zip Code _____

Telephone # _____ Telephone # _____ Telephone# _____
(Home) (work) (pager)

Diagnosis of Alzheimer's disease? Yes [ ] No [ ] Date of Diagnosis ____ / ____ / ____

Other diagnosis's or health problems _____

Special Needs _____

Primary Physician _____ Telephone # _____

How did you hear about our center? _____

Other Services Needed: Support [ ] W/E Respite [ ]

(Office Use Only)

Date Received ____ / ____ / ____ Receipt Letter Mailed _____

Center Visit Date ____ / ____ / ____ _____ ____ / ____ / ____
Admitted? Beginning Date of Service