

## STATEMENT OF SOCIAL HISTORY

Applicant's Name \_\_\_\_\_

Last

First

MI

Present Living Arrangements: Home \_\_\_\_\_ Family \_\_\_\_\_ Hospital \_\_\_\_\_ Nursing Home \_\_\_\_\_ Other \_\_\_\_\_

Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widow(er) \_\_\_\_\_

Religion: Protestant \_\_\_\_\_ Catholic \_\_\_\_\_ Baptist \_\_\_\_\_ Other \_\_\_\_\_ Number of Children \_\_\_\_\_

Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

City

Parish (County)

State

Education/Occupational History \_\_\_\_\_

Legal Problems (If Applicable) \_\_\_\_\_

### INSURANCE INFORMATION

Medicare Part A: Yes \_\_\_\_\_ No \_\_\_\_\_ Part B: Yes \_\_\_\_\_ No \_\_\_\_\_

Private Insurance: Yes \_\_\_\_\_ No \_\_\_\_\_ Policy Number: \_\_\_\_\_

Name of Company \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Please attach a copy of card(s) for all insurance policies. Include Medicare card, also.

### HOSPITAL PREFERENCE

Please complete information requested below. If no preference is listed, the Department of Veterans' Affairs Medical Center or a state health care facility in the immediate area will be utilized.

NAME OF HOSPITAL \_\_\_\_\_

NAME OF PHYSICIAN \_\_\_\_\_ TELEPHONE \_\_\_\_\_

### POST MORTEM INFORMATION

PLEASE ATTACH A COPY OF THE LIFE INSURANCE INFORMATION AND BURIAL INSURANCE POLICY

FUNERAL HOME PREFERENCE \_\_\_\_\_