ACORN Enrollment / Questionnaire Form

Personal Information		
Name:	**☐ Male ☐ Female**	**DOB:**
Address:		
Phone Number:	**SSN:**	
Marital Status: ☐Married ☐Single ☐Separated ☐Widowed	**Spouse's Name:**	
Health Insurance Company:	**Policy Number:**	

Home Access Information			
Key On File: ☐Yes ☐No	**Pets: ☐Yes ☐No**		
Alarm: ☐Yes ☐No	**Alarm Code:**	**Alarm Company:**	**Phone Number:**

Emergency Contact Information			
Name:	**Relation:**	**Phone Number:**	**Address:**
1.			
2.			
3.			

Personal Safety	
Do you live alone? ☐ Yes ☐No	**Do you have restricted mobility? (wheelchair, cane, walker?)**
Do you have frequent falls? ☐Yes ☐No	
Do you have vision loss? ☐ Yes ☐No	**Do you have any Advanced Directives?** **DNR?** **Living Will?** **Healthcare POA?**
Do you have hearing loss? ☐Yes ☐No	

Medical Problems		

Medications		
Medication Name	**Dose**	**Frequency**

Allergies		

Any additional information

I certify that the information on this form is accurate and up-to-date. I also understand that emergency personnel may rely on this information. I agree not to hold emergency personnel responsible for inaccurate or out-of-date information.

Signature_____ Date _____