



CONFIDENTIAL DATA PROFILE
ALL INFORMATION WILL BE HELD CONFIDENTIAL

Directions: Please answer each question as thoroughly as possible. If you are applying for double occupancy, each person is required to complete his or her own profile.

1. Name: _____
Prefix Last First Middle
2. Address: _____
Street City State Zip
3. Telephone No.: (____) _____ Mobile No.: (____) _____
4. Email Address: _____
Do you want your email address listed in the Resident Website Phone Directory after moving to Kāhala Nui? ____yes ____no
5. Birth Date: _____ Current Age: _____
Month Day Year
6. Marital Status: ____ Married ____ Single ____ Widowed ____ Divorced
7. Name of Spouse: _____
8. No. of children: _____ (Contact Information for children is *required*. Complete page 7.)
9. Do you have a Durable Power of Attorney? ____yes ____no
10. Do you have an Advanced Healthcare Directive? ____yes ____no
11. Do you have a Provider Orders for Life-Sustaining Treatment (POLST) form? ____yes ____no
12. Name of Power of Attorney (POA) – Other than Spouse (*Required*): _____
Relationship of POA: _____ Email Address _____
Telephone No.: (____) _____ Mobile No.: (____) _____
Address: _____
Street City State Zip
- 12a. Name of Attorney who prepared Power of Attorney Documents: _____

Confidential Data Profile Continued:

13. FIRST person to notify in case of emergency: _____

Relationship: _____ Email Address _____

Address: _____
Street City State Zip

Telephone No.: (____) _____ Mobile No.: (____) _____

14. SECOND person to notify in case of emergency: _____

Relationship: _____ Email Address _____

Address: _____
Street City State Zip

Telephone No.: (____) _____ Mobile No.: (____) _____

15. What is/was your occupation? _____

16. Veteran: ____yes ____no If YES, what Branch of Service: _____

17. What are your hobbies or interests: _____

18. Church Affiliation: (Optional) _____

19. Would you bring a car? ____yes ____no Electric car? ____yes ____no

20. Would you be bringing a pet? ____yes ____no **If YES, please describe your pet.**

21. Have you ever been convicted of or pleaded nolo contendere to a felony or other crime other than a traffic violation? ____yes ____no

If you have answered YES, please provide an explanation on a separate sheet.

22. Are you capable of Independent Living without help from anyone else, paid or unpaid?

____yes ____no

If NO, please describe the kinds of assistance you currently need.

Confidential Data Profile Continued:

23. Medicare No.: _____ (Hospital A _____ Medical B _____)
Check all that applies.

Supplemental Health Insurance:

Insurer: _____ Policy No.: _____

Long Term Care Insurance: _____

24. Health History: Please list all medical conditions (current/past) including any surgery or procedure you may have had.

25. Have you received your COVID-19 vaccine? ____yes ____no

If yes, which one? _____

If Pfizer or Moderna, have you had both doses? ____yes ____no

When did you receive your last dose? _____

26. Please provide name, address, telephone and fax number of your primary care physician (PCP):

Name: _____

Address: _____
Street City State Zip

Telephone No.: (____) _____ Fax No.: (____) _____

Last Seen: _____

Confidential Data Profile Continued:

27. List all other physicians you see on a regular basis:

Physician: _____ Specialty: _____

Address: _____

Street City State Zip

Telephone No.: (____) _____ Fax No.: (____) _____

Last Seen: _____

Physician: _____ Specialty: _____

Address: _____

Street City State Zip

Telephone No.: (____) _____ Fax No.: (____) _____

Last Seen: _____

Physician: _____ Specialty: _____

Address: _____

Street City State Zip

Telephone No.: (____) _____ Fax No.: (____) _____

Last Seen: _____

Physician: _____ Specialty: _____

Address: _____

Street City State Zip

Telephone No.: (____) _____ Fax No.: (____) _____

Last Seen: _____

(Please list any other physician(s) you are currently seeing on a separate sheet.)

Preferred Hospital: _____

28. Have you been hospitalized or incapacitated within the last 5 years? ____yes ____no

If YES, please explain such details as necessary to understand the condition and outcome.

Confidential Data Profile Continued:

29. Have you ever been treated for depression, anxiety, or any other emotional disorder?
_____yes _____no If YES, please explain:

30. Are you free from contagious disease? _____yes _____no

31. Have you ever been treated for alcoholism or drug dependency? _____yes _____no

If YES, please explain: _____

32. List all current medications, including those prescribed by a physician, over-the-counter and herbals.

Medication	Strength	Directions	Medical Reason

33. Medications: Do you manage your medications? _____yes _____no

Does someone assist you by setting up your pill box or medication reminders? _____yes _____no

34. Do you have any visual impairment or limited vision due to health reasons? _____yes _____no

If YES, please explain: _____

Confidential Data Profile Continued:

35. Do you have any significant hearing loss? ____yes ____no

Do you use hearing aids? ____yes ____no

36. Do you use any assistive devices such as a walker, cane, or scooter? ____yes ____no

37. Do you require continuous or intermittent oxygen? ____yes ____no

38. Are you at risk for falling and have you been hospitalized for a fall? ____yes ____no
If YES, please explain:

39. Please list all Allergies (include food, medication, other).

40. Do you require a special diet or special consistency (minced, chopped, puree) due to swallowing difficulties or health reasons?

To the best of my knowledge, the above statements are complete and true. By signing this Confidential Data Profile, I authorize Kāhala Senior Living Community, Inc. (KSLC) to contact the physicians listed herein and authorize those physicians to disclose my medical information to KSLC.

Prospective Resident Signature

Date

Confidential Data Profile Continued:

Contact information for all children *(Required)*:

Last Name		First Name	
Street	City	State	Zip
Telephone No.: ()		Mobile No.: ()	
Email Address:			

Last Name		First Name	
Street	City	State	Zip
Telephone No.: ()		Mobile No.: ()	
Email Address:			

Last Name		First Name	
Street	City	State	Zip
Telephone No.: ()		Mobile No.: ()	
Email Address:			

Last Name		First Name	
Street	City	State	Zip
Telephone No.: ()		Mobile No.: ()	
Email Address:			

Last Name		First Name	
Street	City	State	Zip
Telephone No.: ()		Mobile No.: ()	
Email Address:			