THE ROSOMOFF COMPREHENSIVE REHABILITATION CENTER

A Department of Douglas Gardens Hospital
5200 NE 2nd Ave, Miami, FL 33137

Phone: (305)532-7246 Fax: (305)795-8488 Email: rehabilitation@rosomoffcenter.com Web: www.rosomoffcenter.com

PATIENT APPLICATION

(Office use only) Date Received:_____

PLEASE COMPLETE ALL QUESTIONS

First name: _____ MI:_____

Last name: _____

Gender: ☐M ☐F SS#:_____

Birth date: _____ Age: _____ Religion: _____

Marital status: ☐M ☐Partner ☐S ☐D ☐W Race: _____

Address: _____

City: _____State: _____ ZIP: _____

Phone - Home: (___)_____ Work: (___)_____

Cell Phone: (___)_____ Fax: (___)_____

Non-Work E-mail: _____

Best time to call you: _____

Do you speak English? ☐Yes ☐No

If No, language spoken: _____

Ethnic Origin: ☐ Caucasian ☐ African American

☐ Hispanic ☐ Asian ☐ Other_____

Working Status: ☐ Employed ☐ Homemaker

☐ Retired ☐ Student ☐ On Disability

Emergency contact name: _____

Address: _____

City: _____State: _____ ZIP: _____

Phone number: (_____)_____

Cell Phone: (_____)_____

Non-Work E-mail: _____

Relationship to you: _____

EMPLOYER / CONTACT INFORMATION:

What is/was your occupation: _____

Your job title: _____

Recent/present employer's name: _____

Address: _____

City: _____State: _____ ZIP: _____

Phone number: (_____)_____

Supervisor's name: _____

Phone: (_____)_____ Fax: (_____)_____

THE FOLLOWING INFORMATION IS REQUIRED IN ORDER TO VERIFY YOUR INSURANCE BENEFITS.
Please attach a copy of your insurance card (s) front and back, including your Medicare card and other insurance.

Do you belong to a Medicare Advantage Plan? ☐Yes ☐No

Your Medicare #: _____- _____- _____- _____

Hospital coverage effective date: _____

Medical coverage effective date: _____

Do you have Medicaid? ☐ Yes ☐ No

Card #: _____

Primary Insurance _____

Address: _____

_____

Phone number: (_____) _____

Subscriber's name: _____

Subscriber's SS#: _____

Subscriber's date of birth: _____

Relationship: ☐ Patient ☐ Spouse ☐ Child ☐ Dependent

Policy / ID#_____

Employer's Name: _____

☐ Group Policy ☐ Individual Policy ☐ HMO

☐ PPO/PPC ☐ POS ☐ Open Access

Secondary Insurance _____

Address: _____

Phone number: _____

Subscriber's name: _____

Subscriber's SS#: _____

Subscriber's date of birth: _____

Relationship: ☐ Patient ☐ Spouse ☐ Child ☐ Dependent

Policy / ID #: _____

☐ Group Policy ☐ Individual Policy ☐ HMO

☐ PPO/PPC ☐ POS ☐ Open Access

Auto Insurance Carrier (Only if your injury is auto related):

_____

Address: _____

Phone number: _____

Claim #: _____

Subscriber's relation to patient: _____

WORK RELATED INJURY INFORMATION

Is your injury work related? ☐ Yes ☐ No

If you answered yes, complete the following:

Date of injury: _____

W/C claim/file #:_____

Employer at time of injury: _____

Contact person: _____

Employer's address: _____

City: _____State: _____ ZIP: _____

Case settled? ☐ Yes ☐ No - If Yes, Date: _____

Medical care open? ☐ Yes ☐ No

Worker's Compensation Carrier: _____

Address: _____

City: _____State: _____ ZIP: _____

Phone: (_____)_____ Fax: (_____)_____

Case Manager's name: _____

Phone: (_____)_____ Fax: (_____)_____

Adjustor's name: _____

Phone: (_____)_____ Fax: (_____)_____

MEDICAL / SOCIAL HISTORY

1. How did you hear about our Center?
   - ☐ Physician:_____
   - ☐ Hospital / Facility:_____
   - ☐ Friend / Former patient:_____
   - ☐ Insurance Carrier / Case Manager:_____
   - ☐ Attorney:_____
   - ☐ Internet / Website:_____
   - ☐ Print / Media:_____

Referring Physician : _____

Specialty: _____

Address: _____

Phone: (____)_____ Fax: (_____)_____

E-mail: _____

Primary Care Physician : _____

Specialty: _____

Address: _____

Phone: (____)_____ Fax: (_____)_____

E-mail: _____

2. What is the diagnosis that you have been given:

_____

_____

_____

3. When did your pain problem begin? _____

   When did your most recent symptoms begin? _____

4. What has occurred in the past 3 months to cause you to seek treatment now?

   _____

   _____

   _____

   _____

5. Is your pain problem due to:
   - ☐ Disease process
   - ☐ Work related injury
   - ☐ Auto accident
   - ☐ Other accident
   - ☐ No apparent reason

   Date of injury/ accident: _____

6. Where is your pain?

   ☐ Neck ☐ Mid back ☐ Low back

   ☐ Shoulder ☐ Hip ☐ Head / Face

   ☐ Knees ☐ Arm or leg ☐ Pelvic / abdominal

   ☐ Other:_____

RELATED CONDITIONS

☐ Fibromyalgia

☐ RSD/CRPS (Chronic Regional Pain Syndrome)

☐ Chronic Fatigue Syndrome

☐ Other _____

7. Do you use any assistive device? ☐ No
   - ☐ Cane ☐ Walker ☐ Wheelchair
   - ☐ Scooter ☐ Brace: Type _____
   - ☐ Other _____

8. **Check all that apply:**

General / Skin / Miscellaneous:

- ☐ Headaches or migraines
- ☐ Dizziness or vertigo
- ☐ Fainting / syncopal episodes
- ☐ History of recent falls
- ☐ Open skin / wounds / current wound care
- ☐ MRSA or other skin infection_____
- ☐ Cancer, type: _____
- ☐ HIV or AIDS
- ☐ Leukemia
- ☐ Hepatitis

Cardiac:

- ☐ High blood pressure
- ☐ Chest pain / angina
- ☐ Palpitations
- ☐ History of heart attack
- ☐ History of open heart surgery or stents
- ☐ Heart murmur
- ☐ Pacemaker and/or defibrillator
- ☐ History of congestive heart failure
- ☐ Under the care of a cardiologist:
  Name:_____
  Phone#:_____
  _

Respiratory:

- ☐ COPD
- ☐ Chronic bronchitis or emphysema
- ☐ Asthma
- ☐ Shortness of breath with activity
- ☐ Daily oxygen use - # hours_____
- ☐ Sleep Apnea / CPAP use (please circle)

Gastrointestinal / Urinary:

- ☐ Acid reflux / GERD
- ☐ Ulcers or GI bleeding
- ☐ Chronic diarrhea / Irritable Bowel Syndrome
- ☐ Crohn's Disease or Ulcerative Colitis
- ☐ Pancreatitis
- ☐ Chronic nausea or vomiting
- ☐ Loss of bladder / bowel control (circle)
- ☐ Chronic constipation
- ☐ Urinary retention/Requires self-catherization
- ☐ Kidney stones / Kidney disease

Musculoskeletal:

- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Gout

Neurological:

- ☐ Neuropathy
- ☐ Paraplegia / Quadriplegia
- ☐ Seizures: Last seizure:_____
- ☐ Memory problems / Dementia
- ☐ Alzheimer's Disease
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ History of stroke or TIA. Date:_____

Vascular:

- ☐ Varicose veins
- ☐ DVT / thromboses / emboli / blood clots

Endocrine:

- ☐ Diabetes
- ☐ Thyroid problems
  (Hypothyroidism / Hyperthyroidism / Hashimoto's)

Mental Health:

- ☐ Depression
- ☐ Anxiety
- ☐ ADD / ADHD
- ☐ Bipolar Disorder / Manic Depression
- ☐ Schizophrenia
- ☐ Suicidal thoughts or plans
- ☐ History of inpatient admission for psychological problem. Date(s):_____
  Where:_____
- ☐ Under the care of a psychiatrist:
  Name:_____
  Phone:_____
  _
- ☐ Under the care of a psychologist / counselor:
  Name:_____
  Phone:_____
  _

Other problems:

- ☐ _____
- ☐ _____

9. What is your weight? _____ Height: _____
   Any recent changes to your appetite?_____

10. Do you smoke? ☐No ☐Yes, _____ #packs a day
    If you previously smoked, how many years?_____
    When did you quit?_____

11. Do you ever drink alcohol? ☐ No ☐Yes,
    type:_____
    ☐ Daily ☐ Weekly ☐ Socially ☐ Rarely

Do you use alcohol to control your pain? ☐No ☐Yes

12. Please list all allergies you have: ☐ No allergies

Allergy:_____ Reaction:_____
Allergy:_____ Reaction:_____
Allergy:_____ Reaction:_____
Allergy:_____ Reaction:_____

13. Are you on a special diet? ☐ Yes ☐ No
☐ Diabetic ☐ Low fat ☐ Low salt ☐ Vegetarian
☐ Lactose intolerant
☐Other:_____

14. List all activities you are no longer able to do (or cannot do safely) because of your pain problem.

_____
_____
_____
_____
_____
_____

15. Have you ever been treated in a drug or alcohol rehabilitation or addiction program? ☐ No ☐Yes
When:_____
_____
Where:_____
_____

16. How many ER visits have you had in the past 6 months for pain? _____

17. Who prescribes your pain medications?
Name:_____
Phone:_____
Type of physician:_____

18. Are you currently involved in any legal activity?
☐ Yes ☐ No
If Yes, indicate type:
☐ Workers compensation ☐ Liability
☐ Malpractice ☐ Personal injury
☐ Other _____

MEDICAL REPORTS:

A copy of all RCRC reports will be sent to your referring physician and your workers compensation carrier (if applicable) as well as those listed below.

☐ Myself ☐ Other Physicians Listed Below

Name: _____
Address: _____
City: _____State: _____ ZIP: _____
Phone: (_____)_____ Fax: (_____)_____
E-mail: _____

Name: _____
Address: _____
City: _____State: _____ ZIP: _____
Phone: (_____)_____ Fax: (_____)_____
E-mail: _____

I, the undersigned, authorize the above parties to receive copies of medical reports from the Rosomoff Comprehensive Rehabilitation Center.

Your Signature: _____

Today's Date: _____ / _____ / _____

PRIVACY STATEMENT:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your protected health information may be used and disclosed by us. It also tells you how you can get access to this information. As a patient, you have the following rights: 1) the right to inspect and copy your information; 2) the right to request corrections to your information; 3) the right to request that your information be restricted; 4) the right to request confidential communications; 5) the right to report of disclosures of your information; and 6) the right to a paper copy of this notice. Our Notice of Privacy Practices is available on our web site: http://www.rosomoffcenter.com. If you would like to receive a paper copy of the notice, please call: (305) 532-7246. You will also be provided with a hard copy of the notice when you come for services or treatment at our Center.

We want to assure you that your health information is secure with us. Please sign below to permit us to use, disclose, and share the health information in this application ONLY with personnel in or outside our facility who may be involved in

reviewing your application, making your appointments, and authorizing services. ***Thank you.***

Your Signature _____

19. **CHECK ALL PRIOR TREATMENTS**

☐ Physical Therapy When:_____ Where:_____
☐ Occupational Therapy When:_____ Where:_____
☐ Pool / Aqua Therapy When:_____ Where:_____
☐ Chiropractic When:_____ Where:_____
☐ Pelvic Floor Therapy When:_____ Where:_____
☐ Biofeedback When:_____ Where:_____
☐ Psychological Counseling When:_____ Where:_____
☐ Inpatient Psychiatric Treatment When:_____ Where:_____
☐ Outpatient Psychiatric Treatment When:_____ Where:_____
☐ Acupuncture When:_____ Where:_____
☐ Massage Therapy When:_____ Where:_____
☐ Trigger Point or Facet Injections When:_____ Where:_____
☐ Epidural Injections When:_____ Where:_____
☐ Other Injections: When:_____ Where:_____
☐ Pain Center: When:_____ Where:_____

☐ Ice ☐ Heating pad/hot pack ☐ TENS Unit or H-Wave ☐ Patches / creams ☐ Hypnosis ☐ Bed rest

20. **LIST ALL SURGERIES YOU HAVE HAD:**

Date: _____Type:_____ Date: _____Type:_____
Date: _____Type:_____ Date: _____Type:_____
Date: _____Type:_____ Date: _____Type:_____
Date: _____Type:_____ Date:_____Type:_____
Date: _____Type:_____ Date: _____Type:_____

21. **LIST ALL MEDICATIONS YOU TAKE**

(Please include prescribed medications and over-the-counter medications such as vitamins, herbs, supplements.)

Medication Name	Dose & Frequency	Reason Taken	Medication Name	Dose & Frequency	Reason Taken
1			11		
2			12		
3			13		
4			14		
5			15		
6			16		
7			17		
8			18		
9			19		

10			20		

Douglas Gardens Hospital
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

Patient Name: _____ _____ _____
Last First Date of Birth Social Security #

I, _____, authorize release of my confidential medical information to:
Print Your Name

Rosomoff Comprehensive Rehabilitation Center
A department of Douglas Gardens Hospital
5200 N.E 2nd Avenue, Miami, Florida 33137 / Phone: (305) 532-7246 Fax: (305) 795-8488

For the purpose of medical consultation, evaluation and or treatment. I authorize release of information covering treatment dates of:

_____

I authorize disclosure of the following types of information:

____ Medical / Surgical / Hospital / Physician Reports
____ Special: ____Drug & Alcohol Treatment ____Mental Health ____HIV/AIDS ____Sexual Abuse Treatment
____ Discussions with: ____Treating Team ____Psychiatrist / Psychologist Other: _____
____ Family / Significant Others (list): _____ _____
_____ _____

I understand that under Florida Law the classification of records checked above relating to treatment rendered to me are privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to persons and agencies other than those designated by me or my personal representative or otherwise provided in Florida law.

Understandings & Agreements of Requestor

1. This authorization is voluntary and I understand that the facility cannot condition treatment based on the signing of this authorization, unless the authorization is (a) for research-related treatment, or (b) solely for the purpose of creating health information for the use or disclosure to a third party.
2. I understand that I may revoke this authorization at any time by notifying the facility in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
3. I agree to waive all claims against the facility for the release of the requested information.
4. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by the facility if the recipient of the information is not a health plan, health care provider, health care clearinghouse, or a business associate that has a contract with the facility.
5. I understand that the Miami Jewish Health Systems will release only the minimum amount of information necessary to fulfill a request. Unless otherwise revoked, this authorization will expire six months from the date of the signature listed below.

_____ _____ ___/___/___
Signature of person making the request Print Name Date

_____ _____ ___/___/___
Authorized Signature Print Name Date

_____ _____ ___/___/___
Witness Print Name Date

☑ Return this completed form with your application and give a copy to your own physician / hospital prior to your arrival.

Per Florida Statute 400.145, there is a fee assessed for copies of records. The facility requires prepayment of these fees before release of the copies.