

THE ROSOMOFF COMPREHENSIVE PAIN CENTER

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

Phone: (305) 532-7246

Fax: (305) 795-8488

E-mail: rehabilitation@rosomoffcenter.com

PATIENT APPLICATION

For Office use only: Received: _____ Serial #: _____

Seen by: Fernando Branco, MD Serge Podrizki, MD Susan Compton, MCMSc, PA-C
 Psychologist: _____ Date(s) Seen: _____

Please complete all items. Missing information may delay admission.

PERSONAL INFORMATION

First name: _____ MI: _____

Last name: _____

Gender: M F SS#: _____

Birth date: _____ Age: _____ Religion: _____

Marital status: M 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 Oriental
 Other _____

Working Status: Employed Homemaker
 Retired Student
 On Disability Other _____

Emergency contact person: _____

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: (____) _____

INSURANCE INFORMATION

INFORMATION BELOW MUST INCLUDE FULL ADDRESSES AND PHONE NUMBERS TO VERIFY BENEFITS (Please attach a copy of your Insurance Card including your Medicare Card and Commercial Insurance)

Do you belong to a Medicare HMO? Yes No

Your Medicare #: _____ - _____ - _____ - _____

Hospital coverage effective date: _____

Medical coverage effective Date: _____

Do you have Medicaid or Medipass? Yes No

Card #: _____

Primary Insurance _____

Address: _____

Phone number: (____) _____

Subscriber's name: _____

Subscriber's SS#: _____

Subscriber's date of birth: _____

Relationship: Patient Spouse
 Child Dependent

Group #: _____

Employer Name: _____

Group Policy Individual Policy HMO

PPO/PPC POS

INSURANCE INFORMATION (continued)

Secondary Insurance _____

Address: _____

Phone number: _____

Subscriber's name: _____

Subscriber's SS#: _____

Subscriber's date of birth: _____

Relationship: Patient Spouse
 Child Dependent

Group name and #: _____

Group Policy Individual Policy HMO

PPO/PPC POS

Auto Insurance (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 the Comprehensive Pain Center?
(Please be specific and write the name of the doctor, name of friend, former Pain Center patient, magazine, newspaper, radio, TV station/program or other)

1. If you were referred by a physician you **MUST** complete the following:

Referring Physician name: _____

Specialty: _____

Address: _____

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

E-mail: _____

Primary Physician name: _____

Specialty: _____

Address: _____

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

E-mail: _____

What is the diagnosis that you have been given: _____

3. What was the date your pain problem began:

When did your most recent symptoms begin? _____

4. What has occurred in the past 6 months to cause you to seek treatment for your current condition:

- Palpitations
- History of heart attack
- History of open heart surgery
- History of cardiac stents
- Pacemaker and/or defibrillator
- History of congestive heart failure
- Under the care of a cardiologist:
Name: _____

5. Was the problem due to:

- Disease process
- Work injury
- Auto accident
- Other accident
- No apparent reason

Date of injury/ accident: _____

Breathing problems

- COPD
- Chronic bronchitis or emphysema
- Asthma
- Shortness of breath
- Oxygen use

Digestive / Stomach problems

- Acid reflux / GERD
- Stomach ulcer
- Irritable Bowel Syndrome
- Crohn's Disease

Musculoskeletal Problems:

- Osteoarthritis
- Rheumatoid Arthritis
- Gout

Neurological Problems:

- Neuropathy
- Paralysis
- Fainting / syncope
- Seizures: Last seizure: _____
- Memory problems
- Alzheimer's Disease
- Parkinson's Disease
- Multiple Sclerosis
- History of stroke

Endocrine Problems:

- Diabetes Mellitus
- Thyroid problem

Psychological Problem:

- Depression
- Anxiety
- Bipolar Disorder
- Schizophrenia

6. Where is your pain?

- Neck
- Upper back
- Low back
- Shoulder
- Hip
- Headache
- Knee
- Extremity
- Other _____

RELATED CONDITIONS

- Fibromyalgia
- RSD (Chronic Regional Pain Syndrome)
- Other _____

7. Do you require the use of an assistive device?

- Cane
- Walker
- Wheelchair
- Scooter
- Brace: Type _____
- Other _____

8. Do you have any other medical problems? (check all that apply)

General:

- Headaches
- Dizziness
- Vertigo
- History of recent falls
- Open skin or wound
- Cancer, type: _____

Heart / Cardiac Problems:

- High blood pressure
- Chest pain / angina

- History of inpatient admission for psychological problem
- Under the care of a psychiatrist:
Name: _____
- Under the care of a psychologist:
Name: _____

Other Medical Problems:

- List: _____

8. What is your weight? _____ Height: _____
9. Do you smoke? No Yes, _____ #packs a day
10. Do you use alcohol?
 Regularly Occasionally Never

11. Please list all allergies you have: _____

12. Are you on a special diet? Yes No
If Yes, what kind: _____

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

18. What are your expectations of our program? _____

19. Please list any questions you would like answered:

WHO SHOULD RECEIVE MEDICAL REPORTS THAT WILL BE GENERATED BY OUR CENTER? (A copy of all RCPC reports will be sent to your referring physician and everyone else you have listed here)

- Myself No one else other than my referring physician
- Name: _____

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

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

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

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

NO REPORTS WILL BE SENT UNLESS YOU COMPLETE THIS PART...

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.rosomoffpaincenter.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.

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 _____

We want to assure you that your health information is secure with us. Please sign below to permit us to use, disclose, and

ACTIVITIES OF DAILY LIVING	Able To Do	I Require Assistance	Unable To Do Because Of Pain
1. Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Feeding yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Transferring to/from bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Transferring to/from toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Transferring to/from shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Transferring to/from wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Transferring to/from car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Cleaning the house	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Cooking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Yard work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Child care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Pet care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Grocery shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Banking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Work outside home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Volunteer activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Leisure activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Hobbies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

31. Travel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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PRIOR TREATMENTS

HAVE YOU HAD PREVIOUS TREATMENT FOR YOUR CURRENT CONDITION (check all that apply):

- Physical Therapy:** when: _____ where: _____ Inpatient / Outpatient (circle)
- Occupational Therapy:** when: _____ where: _____ Inpatient / Outpatient (circle)
- Chiropractic:** when: _____ where: _____ Inpatient / Outpatient (circle)
- TENS:** when: _____ where: _____ Inpatient / Outpatient (circle)
- Biofeedback:** when: _____ where: _____ Inpatient / Outpatient (circle)
- Psychological Counseling:** when: _____ where: _____ Inpatient / Outpatient (circle)
- Psychiatric Treatment:** when: _____ where: _____ Inpatient / Outpatient (circle)
- Bed Rest:** when: _____
- Acupuncture:** when: _____ where: _____ Inpatient / Outpatient (circle)
- Massage:** when: _____ where: _____ Inpatient / Outpatient (circle)
- Trigger Point Injection:** when: _____ where: _____ Inpatient / Outpatient (circle)
- Epidural Injections:** when: _____ where: _____ Inpatient / Outpatient (circle)
- Other _____: when: _____ where: _____ Inpatient / Outpatient (circle)
- Other _____: when: _____ where: _____ Inpatient / Outpatient (circle)
- Other _____: when: _____ where: _____ Inpatient / Outpatient (circle)

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: _____

Date: _____

Type: _____

Date: _____

Type: _____

Date: _____

Type: _____

Date: _____

Type: _____

Date: _____

Type: _____

Date: _____

Type: _____

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

(305) 532-7246 x8477

Fax (305) 795-8488

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

I, _____, authorize:
Print your name

Name of health care facility Phone number Fax number

to release my health information to:

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: ___ Doctor Appt ___ Comprehensive Evaluation and/or Treatment

I authorize release of information covering treatment dates of: _____

The type and amount of information to be disclosed is as follows:

- ___ History and Physical
- ___ Consultations
- ___ Discharge Summary
- ___ Physician Progress Notes
- ___ Physicians Orders
- ___ Laboratory Reports
- ___ Radiology Reports
- ___ Therapy Records
- ___ Nurses' Notes
- ___ Insurance / Financial Information
- ___ Other: _____

Information and/or records related to:

___ 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 Home and Hospital for the Aged 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

<input checked="" type="checkbox"/> Send this form back to: The Rosomoff Comprehensive Rehabilitation Center A department of Douglas Gardens Hospital 5200 NE 2nd Ave, Miami, FL 33137 Fax: (305) 795-8488
<input checked="" type="checkbox"/> Give a copy of this form to your own private Doctor or Hospital facility where you were treated so they can forward a copy of your medical records to us.

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.

