The Summit at Brighton

Medical Registration Form - Admission

Last Name	First Name	Middle	Date of Birth	Gender Identity	Assigned Gender
Preferred Name:					
Preferred Pronouns:					

Insurance Information (Not needed for waitlist application)	
Medicare Part A Policy #	
Medicare Part B Info and Policy #	
Medicare Part D Info and Policy #	
Secondary / Other Insurance Company Info & Policy #	
Secondary / Other Insurance Company Info & Policy #	

Emergency Contact Information (Not needed for waitlist application)			
Emergency Contact #1			
Name		Relationship	
Health Care Agent Yes ☐ No ☐		Power of Attorney Yes ☐ No ☐	
Phone			
Address			
Email			
Emergency Contact #2			
Name		Relationship	
Health Care Agent Yes ☐ No ☐		Power of Attorney Yes ☐ No ☐	
Phone			
Address			
Email			

Physician(s)			
Primary Care Physician			
Name		Phone	

Specialists (Not needed for waitlist application)

Name		Phone	
Specialty		Seen in past 12 months? Yes ☐ No ☐	
Name		Phone	
Specialty		Seen in past 12 months? Yes ☐ No ☐	
Name		Phone	
Specialty		Seen in past 12 months? Yes ☐ No ☐	
Name		Phone	
Specialty		Seen in past 12 months? Yes ☐ No ☐	
Name		Phone	
Specialty		Seen in past 12 months? Yes ☐ No ☐	

Allergen	Reaction

Advance Directive Information - Please check all that apply (Please bring copies to file at admission)

☐ Health Care Proxy	☐ Living Will	☐ MOLST Form
☐ Other		

Procedure or reason for hospitalization	Date	Location/Hospital

TOBACCO				
☐ Yes ☐ No	☐ Current	☐ Quit	Date Quit:	
	☐ Cigarettes	☐ Cigars	☐ Pipe	☐ Other
	How Many / Day?		How Many Years?	
ALCOHOL				
☐ Yes ☐ No	☐ Beer	☐ Wine	☐ Liquor	☐ Other
	How Many / How Often?		Date Quit:	
WEIGHT GAIN or LOSS				
☐ Yes ☐ No	Has your weigh increased or decreased by 10 pounds or more in the past year / 12 months?			
	Gain ___ lbs.	Loss ___ lbs.	Reason:	
EXERCISE				
☐ Yes ☐ No	Do you exercise regularly?			
	What kind?		Days/Week:	
DRUG USE				
☐ Yes ☐ No	Do you use recreational drugs? If yes, please explain:			

Immunization Information - Check all that apply Or provide a copy of Immunization Record (Not needed for waitlist application)			
Vaccine	Date	Date	Date
☐ Influenza			
☐ COVID-19			
☐ Tdap			
☐ Hepatitis A			
☐ Hepatitis B			
☐ Shingrix			
☐ Zostavax			
☐Prevnar 13 (PCV13)			
☐ Prevnar 15 (PCV15)			
☐ Prevnar 20 (PCV20)			
☐ Pneumovax 23 (PPSV23)			
☐ Other:			
☐ Other:			
☐ Other:			
☐ Other:			

Medical History / Current Conditions (check all that apply)

☐ No Known Medical Conditions	☐ Implants (breast, eye, penile, etc.) Specify:
☐ Anemia	
☐ Anxiety	☐ Injuries / Accidents Specify:
☐ Asthma	
☐ Arthritis	☐ Kidney Failure
☐ Alzheimer's Disease	☐ Kidney Stones
☐ Benign Prostatic Hypertrophy (BPH)	☐ Other Kidney / Bladder Issues Specify:
☐ Bleeding	
☐ Bronchitis	☐ Measles
☐ Cancer Specify:	☐ Memory Impairment
	☐ Mild Cognitive Impairment
☐ Cataracts	☐ Other Mental Health Concerns Specify:
☐ Chronic obstructive pulmonary Disease (COPD)	
	☐ Mumps
☐ Dementia other than Alzheimer's Specify:	☐ Poliomyelitis
	☐ Prostate Disease
☐ Diabetes Insulin use: ☐ Yes ☐ No	☐ Rheumatic Fever
	☐ Rheumatoid Arthritis
☐ Emphysema	☐ Scarlet Fever
☐ Gastroesophageal Reflux Disease (GERD)	☐ Seizure Disorder
	☐ Stroke / Cerebrovascular Disease
☐ Glaucoma	☐ Skin Issues Specify:
☐ Hearing Loss	
☐ Heart Disease	☐ Other:
☐ Hepatitis Specify:	☐ Other:
	☐ Other:
☐ High Blood Pressure (Hypertension)	☐ Other:
☐ High Cholesterol or Triglycerides	☐ Other:
☐ Incontinence	☐ Other:
☐ Additional Health Information or Explanations:	

Review of Systems – Check ALL That Apply (Not needed for waitlist application)			
General			
☐ Fatigue ☐ Sweats ☐ Heat Intolerance	☐ Weight Loss ☐ Weakness ☐ Cold Intolerance	☐ Weight Gain ☐ Fever ☐ Chills	
Skin			
☐ Itching	☐ Rashes	☐ Hives	☐ Easy Bruising
☐ Hair Loss	☐ Abnormal Moles	☐ Eczema	☐ Open Areas
Head, Eyes, Ears, Nose, Throat			
☐ Pain	☐ Vision Loss	☐ Glasses	☐ Contacts
☐ Cataracts	☐ Blurry Vision	☐ Dry Eyes	☐ Excessive Tears
☐ Red Eyes	☐ Itchy Eyes	☐ Hearing Loss	☐ Ear Ringing
☐ Hearing Aids	☐ Ear Discharge	☐ Ear Infection	☐ Sore Throat
☐ Cough	☐ Swollen Glands	☐ Runny Nose	☐ Nose Bleeds
☐ Sinus Pain	☐ Sinus Congestion	☐ Post-nasal Drip	☐ Hoarseness
☐ Excessive Salivation	☐ Swallowing Issues	☐ Thyroid Problems	☐ Masses/Lumps
☐ Bleeding Gums	☐ Infections	☐ Goiter	☐ Stiff Neck
Respiratory			
☐ Shortness of Breath	☐ Wheezing	☐ Pneumonia	☐ Pain Breathing
☐ Phlegm	☐ Coughing Blood	☐ Tuberculosis	☐ Other Lung Disease
Cardiovascular			
☐ Chest Pain	☐ Leg Swelling	☐ Valve Disease	☐ Rheumatic Fever
☐ Difficulty Lying Flat	☐ Poor Circulation	☐ Murmur	☐ Arrythmia
☐ Palpitations	☐ Heart Failure	☐ Passing Out	☐ Heart Attack
☐ Varicose Veins	☐ Blood Clots	☐ Raynaud Syndrome	☐ Skin Ulcers
Chest			
☐ Nipple Discharge	☐ Breast Mass	☐ Pain	☐ Lump / Mass
Gastrointestinal			
☐ Stomach Pain	☐ Nausea	☐ Vomiting	☐ Heartburn
☐ Loss of Appetite	☐ Blood in Stool	☐ Jaundice	☐ Gall Bladder Issues
☐ Liver Problems	☐ Constipation	☐ Diarrhea	☐ Incontinence
☐ Hemorrhoids	☐ Abnormal Stool	☐ Abdominal Swelling	☐ Masses
Urinary			
☐ Incontinence	☐ Blood in Urine	☐ Burning	☐ Pain with Voiding
☐ Urgency	☐ Frequency	☐ Discharge	☐ Difficulty Voiding
☐ Waking to Void	☐ Flank Pain	☐ Frequent Infections	☐ Kidney Stones
Male			
☐ Lesions	☐ Discharge	☐ Pain	☐ Masses
☐ Prostate Issues	☐ Hernia	☐ Impotence	☐ STD
Female			
☐ Abnormal Bleeding	☐ Discharge	☐ Pain	☐ Dryness
☐ Itching	☐ Hernia	☐ Abnormal PAP	☐ STD
Musculoskeletal			

☐ Joint Pain	☐ Gout/Pseudogout	☐ Muscle Pain	☐ Muscle Weakness
☐ Joint Stiffness	☐ Back Pain	☐ Difficult Walking	☐ Falls
Neurological			
☐ Fainting	☐ Dizziness	☐ Blackouts	☐ Numbness
☐ Tingling	☐ Burning	☐ Tremors	☐ Paralysis
☐ Spasms	☐ Seizures	☐ Unsteady Gait	☐ Memory Loss
☐ Difficulty Sleeping	☐ Excessive Sleepy	☐ Headaches	☐ Speech Problems
Psychological			
☐ Depression	☐ Anxiety	☐ Hallucinations	☐ Mania
☐ Difficulty Focusing	☐ Mood Swings	☐ Paranoia	☐ Agitation

Family History (Not needed for waitlist application)			
Relationship	Status	Age	Health Conditions
Mother	☐ Alive ☐ Deceased		
Father	☐ Alive ☐ Deceased		
	☐ Alive ☐ Deceased		
	☐ Alive ☐ Deceased		
	☐ Alive ☐ Deceased		
	☐ Alive ☐ Deceased		
	☐ Alive ☐ Deceased		
	☐ Alive ☐ Deceased		
	☐ Alive ☐ Deceased		

Current Medications			
Please include all prescription <u>and</u> over-the-counter medications, vitamins & supplements. Attach additional pages as necessary.			
MEDICATION	DOSAGE	FREQUENCY	INDICATION

Note to prospective resident: Documentation will be kept on file in the Administrative Offices in accordance with HIPAA regulations and will be used in the event of a medical or other emergency.

I acknowledge that this form, along with all medical records obtained from external healthcare providers, will undergo thorough review by designated representatives of Jewish Senior *Life* as an integral component of the residency application process.

The information presented within this Medical Registration Form, as well as the accompanying supporting documentation, faithfully represents my complete medical history, recognizing that any omissions or inaccuracies could result in the revocation of an admission offer or termination of a signed life care contract.

I am fully aware that Jewish Senior *Life* will utilize this form to inform decisions regarding the appropriate living arrangements that ensure the well-being and safety of both myself and fellow residents within the community.

_____

Prospective Resident Signature

_____ _____

Name Printed Date