The Summit
at Brighton
Life Care Senior Living

CONFIDENTIAL DATA APPLICATION
HEALTH INFORMATION FORM

THE SUMMIT AT BRIGHTON
2000 SUMMIT CIRCLE DRIVE
ROCHESTER, NY 14618
(585) 442-4500

Confidential Data Application

HEALTH INFORMATION FORM

NAME: First Person ________________________________ DOB _______________

Social Security # ____________________________

NAME: Second Person ______________________________ DOB _______________

Social Security # ____________________________

	First Person		Second Person	
Medicare #	______________________		___________________________	
Medicare Part B Coverage	☐ YES	☐ NO	☐ YES	☐ NO
Religion:	______________________		___________________________	
Occupation:	______________________		___________________________	
Race:	______________________		___________________________	

Other Supplemental Hospital Insurance (i.e. Preferred Care, Blue Choice Senior)

List Company Name & Phone Number	First Person	Second Person
____	Policy # _____________________	_____________________
____	Policy # _____________________	_____________________

HEALTH INFORMATION

1. Are you capable of carrying on your normal routines without assistance from anyone else?

   First Person ___ YES ___ NO Second Person ___ YES ___ NO

2. Please list any medications that you are presently taking or have taken in the last one-year. (Include non-prescription medicines).

   First Person ____
   ____

   Second Person ____
   ____

3. Please list any medical problems or diagnoses you have (ongoing health concerns of your doctor, significant problems you've had in the past, surgeries, hospitalizations and reasons for them).

First person	Second person
____	____
____	____
____	____
____	____
____	____
____	____
____	____

4. Do you have, have you ever had or have you ever been told by a physician, nurse practitioner or physician assistant that any of the following might affect you, (please provide more information for any "yes" answers on the space provided below.)

	First person		Second Person	
Heart disease, coronary artery disease, or (congestive) heart failure	___ Y	___ N	___ Y	___ N
Cancer ____________________	___ Y	___ N	___ Y	___ N
Stroke, TIA, or "Mini-stroke"	___ Y	___ N	___ Y	___ N
Dementia, Alzheimer's disease, Memory problems	___ Y	___ N	___ Y	___ N
Parkinson's Disease or other movement disorder or problem	___ Y	___ N	___ Y	___ N
Spinal Stenosis	___ Y	___ N	___ Y	___ N
Multiple Sclerosis	___ Y	___ N	___ Y	___ N
Any psychiatric diagnosis, hospitalization, or medication use for a mood, behavioral or psychiatric problem	___ Y	___ N	___ Y	___ N

____
____
____
____
____
____
____
____
____

5. Please describe any major change in your health status or your ability to function and/or socialize in the past three years.

First Person ____
____

Second Person ____
____

6. Please give name, address and telephone of primary care physician.

First Person ______________________ Second Person ______________________
_________________________________ _________________________________
_________________________________ _________________________________
_________________________________ _________________________________

7. Please list other physicians, including specialists, you have seen in the last two years; physician name, address, telephone.

First Person ____
____

Second Person ____
____

8. Are you able to:

	First Person	Second Person
walk without a wheelchair or walker?	___ Y ___ N	___ Y ___ N
Is your pace of walking slower than the average 60-70 year old	___ Y ___ N	___ Y ___ N
dress and bathe without assistance?	___ Y ___ N	___ Y ___ N
manage your own medications?	___ Y ___ N	___ Y ___ N
do your own shopping?	___ Y ___ N	___ Y ___ N
do your own cooking?	___ Y ___ N	___ Y ___ N

9. Please list 2 people who can be contacted in the event of an emergency:

name ____________________ name ____________________

address____________________ address____________________

state/zip ____________________ state/zip ____________________

telephone ____________________ telephone ____________________

email____________________ email____________________

relationship____________________ relationship____________________

10. Do you have advanced directives i.e. living will, DNR order, health care proxy? (Please attach a copy.)

☐YES ☐ NO DNR _______ Living Will _______ Health care proxy _______

I acknowledge that my acceptance into The Summit at Brighton (the Sponsor) will be determined by the Approval Committee of The Summit at Brighton based on this application and other information I have provided to the Sponsor. I hereby authorize the Sponsor's Medical Director to contact my primary care or other physician to review my medical history. I understand that, prior to approving this application the Approval Committee may request additional information concerning my health. I hereby authorize the Sponsor to release my medical information deemed necessary to make an approval determination to persons involved in the approval process. I hereby declare that all statements made herein and other information provided are true according to my best knowledge and belief, and realize that false information or omissions could jeopardize or void my agreement for life care services. In witness whereof I have hereto set my hand to this application this _________ day of ____________________, 20 _______.

____________________ ____________________

First Person Second Person

Person Preparing this Form: ____________________

FOR OFFICE USE ONLY

Medical Record #____________________ New Telephone # ____________________

Move In Date ____________________ Apartment # ____________________