MVS Woundcare & Hyperbarics

Patient Registration Form

Today's Date: _____

NAME: _____ DATE OF BIRTH: _____AGE: _____

HOME ADDRESS_____

HOME PHONE #: _____ CELL# _____ WORK: _____
WHERE DO YOU PREFER MESSAGES LEFT: HOME PHONE / CELL / WORK / OTHER _____

PRIMARY EMAIL ADDRESS:_____

SOCIAL SECURITY #: _____ SEX: M / F MARITAL STATUS: S / M / D / W / LP

RACE: _____ LANGUAGE: _____ ETHNICITY: _____

EMPLOYMENT STATUS: STUDENT / NOT EMPLOYED / FT / PT / RETIRED / DISABLED

Do you receive services from Home Health, Assisted Living, Nursing Home facility? **YES / NO**
IF YES: Agency name or case worker: _____ Phone #: _____

Do you have an Advance Directive Order completed? **YES / NO** If YES would you provide us with a copy? **YES / NO**
Would you like to discuss Advance Directive with the Doctor today? **YES / NO**

PRIMARY INSURANCE: _____MEMBER ID: _____

GROUP #: _____EFFECTIVE DATE: _____

SECONDARY INSURANCE: _____MEMBER ID: _____

GROUP #: _____ EFFECTIVE DATE: _____

EMERGENCY CONTACT NAME: _____RELATIONSHIP: _____

EMERGENCY CONTACT HOME #: _____CELL #: _____

Please list the doctor's names that pertain to your healthcare:

Referring Doctor: _____ Phone Number: _____

Primary Care Doctor: _____ Phone Number: _____

Cardiologist: _____ Phone Number: _____

Podiatrists: _____ Phone Number: _____

Endocrinologists: _____ Phone Number: _____

Nephrologists: _____ Phone Number: _____

HEALTH HISTORY

PLEASE BRIEFLY DESCRIBE THE REASON FOR YOUR VISIT

_____

_____

ANY RECENT TESTING DONE PERTAINING TO THIS VISIT? YES / NO If yes, please list test and where it was done:

_____

_____

Do you have any current wound(s)? Y / N If yes location of wound: _____

How did the wound occur: Injury / Surgical / Infection / Appeared Gradually / Unknown

What wound care treatment are you using: _____

Prior antibiotic therapy or surgical interventions for your current wound(s): YES / NO

HAVE YOU HAD ANY OF THE FOLLOWING IMMUNIZATIONS?

TETANUS: YES / NO Date received: _____ FLU SHOT: YES / NO Date received: _____

PNEUMONIA: YES / NO Date received: _____ HEPATITIS B: YES / NO Date received: _____

ALLERGIES TO MEDICATIONS & REACTION

1. _____ **4.** _____
2. _____ **5.** _____
3. _____ **6.** _____

CURRENT LIST OF MEDICATIONS & SUPPLEMENTS

Medication Name	Dosage	Frequency	Reason for medication
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

DO YOU HAVE A PACEMAKER OR OTHER IMPLANT or MEDICAL DEVICES YES / NO

If YES, please list: _____

LIST ANY SURGERIES YOU HAVE HAD (please include date)

1. _____ **4.** _____
2. _____ **5.** _____
3. _____ **6.** _____

HEALTH CONDITIONS

Have you ever been treated/diagnosed with any of the following: (check all that apply)?

☐ Diabetes	☐ Glaucoma	☐ Cancer
☐ Liver problems	☐ Pneumothorax	☐ Recent Viral Infection
☐ Chemotherapy/ Radiation	☐ Pulmonary Disease	☐ Cellulitis
☐ Sickle Cell Anemia	☐ Stroke	☐ Arthritis
☐ Low Blood Pressure	☐ High Blood Pressure	☐ Poor Circulation (PVD)
☐ Thyroid Disorders	☐ Palpitations	☐ Blood Clots
☐ Weight Change	☐ Sinus Problems	☐ Claustrophobia
☐ Varicose Veins	☐ Immune Deficiency	☐ Anxiety Attacks
☐ Ear Problems	☐ Heart Attack / Angina	☐ Kidney Trouble
☐ Ankle Swelling	☐ Numbness/Tingling/Burning	☐ Asthma

☐ Seizures *(now or in the past)*

SOCIAL HISTORY

TOBACCO USER: NEVER / FORMER / SOCIAL / DAILY TOBACCO TYPE_____ amount per day:_____

ALCOHOL CONSUMPTION: NO / YES How many drinks per week on average: _____

ILLICIT/ RECREATIONAL DRUG USE: NEVER / IN THE PAST / CURRENT USER _____

DO YOU WEAR ANY OF THE FOLLOWING: (check all that apply)?
☐ Glasses ☐Contacts ☐ Dentures ☐ Hearing Aid

Please check one: ☐ Walks independently ☐ Uses a cane or walker ☐ Uses a wheelchair ☐ Non Ambulatory

FAMILY HISTORY

PLEASE LIST ANY FAMILY MEDICAL HISTORY THAT YOU ARE AWARE OF

MOTHER: _____
FATHER: _____
SIBLINGS: _____
MATERNAL GRANDMOTHER: _____
MATERNAL GRANDFATHER: _____
PATERNAL GRANDMOTHER: _____
PATERNAL GRANDFATHER: _____

Pharmacy Name:_____ **Phone Number:**_____

Patient Acknowledgement/Consent Form/ Use & Disclosure of Protected Health Information

I acknowledge I have received a copy of the Notice of Privacy Practices, I understand a copy will be provided to me should I request another.

I acknowledge that I understand that I may ask at any time a copy of the Patient's Bill of Rights and Responsibilities.

I authorize the Practice to leave a detailed message regarding my appointments or medical care as described below.

On an answering machine?	YES	NO
On Voicemail at home or work?	YES	NO
On a cell phone?	YES	NO
With another person?	YES	NO
Through the mail?	YES	NO

Please list any individuals with whom we can discuss your medical care or financial account.

Name	Relationship	Phone

If you would not like us to discuss your care or account with any one, please initial here: _____

Please circle one:

I, AUTHORIZE / DO NOT AUTHORIZE photographs and/or video to be taken of my wound or Hyperbaric treatment to document progress on a regular basis. I further authorize these photographs to be used by MVS Wound Care and Hyperbarics for tools of teaching, marketing and/or educational purposes.

PATIENT'S AUTHORIZATION

I request that payment of authorize Medicare/ Insurance carrier benefits be made on my behalf to MVS Wound Care and Hyperbarics for any services furnished to me by MVS Wound Care and Hyperbarics. I authorize any holder of medical information about me to release to the Centers for Medicare/ Medicaid Services and its agent and/or any other insurance carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatments plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted insurance carrier agreements. I authorize the use of this signature on all insurances submissions, and a copy of this authorization to be used in place of the original.

_____ _____

Signature of PATIENT or AUTHORIZIED REPRESENTATIVE **DATE**

_____ _____

Print Name of Authorized Representative **RELATIONSHIP**