HyperHeal
Wound Care & Hyperbarics

Patient Registration Form

Today's Date: ________________

NAME: ____ DATE OF BIRTH: _______________AGE: ______

ADDRESS: ____

CITY: _______________________________ STATE: ____________ ZIP CODE: ________________

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 HyperHeal 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 HyperHeal Wound Care and Hyperbarics for any services furnished to me by HyperHeal 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**