Welcome to Advanced Wound Institute!

We are OBSESSED with Patient Care! It all starts with getting to know you, to ensure we provide the best possible care. There is a lot here, but we know you can do it! Please fill out the information below as completely as possible. As always, if you have any questions, all of us will help (but maybe not all of us at once).

Patient Name: _____ Date of Birth: _____

Wound History

Wound location: _____

When did you first notice the wound? _____

Has it ever healed and then re-opened? ☐ Yes ☐ No

How did your wound start?

□ Bite	□ Blister	□ Bruise	□ Thermal Burn
□ Bump	□ Chemical Burn	□ Footwear	□ Trauma
□ Frostbite	□ Gradually Appeared	□ Not Known	□ Surgical
□ Pimple	□ Pressure	□ Radiation Burn	□ Other Lesion

Are you taking any antibiotics? ☐ No ☐ Yes

If Yes, what antibiotics? _____

Have you been treating your wound until now? ☐ No ☐ Yes

If Yes, with what? _____

Have you had any lab work done in the past month? ☐ No ☐ Yes

If Yes, which lab? _____

Which ordering doctor or office? _____

Have you had any tests for blood flow in your legs? ☐ No ☐ Yes

If Yes, Date: _____

If Yes, where was it done: _____ Who ordered? _____

Have you had any other problems with your wound?

☐ Infection ☐ Swelling ☐ Draining ☐ Odor ☐ Other

Hospitalization History

Have you had any hospital / Urgent Care visits in the last 90 days? ☐ No ☐ Yes

Date:	Reason you were in the Hospital	Facility:

Surgeries

Date:	Procedure:

Social Use

Do you smoke cigarettes or e-cigarettes (“vape”)? ☐ No ☐ Yes

If so, how many packs a day or week? _____ How many cigarettes a day? _____

If applicable, at what age did you start? _____ At what age did you stop? _____

Do you drink alcohol? ☐ No ☐ Yes

How many drinks per day? _____

How many drinks monthly?
2 to 4 times a month: _____
3 to 4 times a week: _____
4 or more times a week: ____

Do you use recreational drugs? ☐ Yes ☐ No

If yes, types: _____

_____

Patient Health Checklist

Please indicate whether you have experienced any of the following…

General:

- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Fatigue
- ☐ Malaise
- ☐ Weight loss
- ☐ Anemia
- ☐ Low Iron
- ☐ Sickle Cell Disease
- ☐ Hypotension (Low blood pressure)
- ☐ Vasculitis (inflammation of your blood vessels)
- ☐ Cirrhosis (Liver problems)
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ End Stage Renal Disease (Kidney disease)
- ☐ Dialysis
- ☐ Lupus
- ☐ Cancer / Chemotherapy

Respiratory:

- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Asthma
- ☐ Wheezing
- ☐ Aspiration
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Chronic Sinus Problems/ Congestion
- ☐ Pneumothorax (Collapsed lung)
- ☐ Sleep Apnea (Stop breathing wen sleeping)
- ☐ Tuberculosis (Infection in the lungs)

Cardiovascular:

- ☐ Chest discomfort
- ☐ Angina (Chest pains)
- ☐ Palpitations
- ☐ Arrhythmia (Skipped heartbeats)
- ☐ Swelling in ankles or feet
- ☐ Fluttering feeling in chest
- ☐ Atrial Fibrillation (Rapid heart rate)
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease (Heart disease)
- ☐ Myocardial Infarction (Heart attach)

Neurological:

- ☐ Seizures
- ☐ Memory Loss
- ☐ Vertigo
- ☐ Weakness
- ☐ Numbness/tingling
- ☐ Stroke
- ☐ Paraplegia / Quadriplegia (Can't move arms and legs)
- ☐ HTN, HLD, CVA, or TIA

When?

_____

Psychological:

- ☐ Depression
- ☐ Anxiety
- ☐ Memory loss
- ☐ Unusual stress
- ☐ Mental disturbance

Musculoskeletal:

- ☐ Arthritis
- ☐ Back pain
- ☐ Joint pain
- ☐ Muscle weakness

Extremities:

- ☐ Edema
- ☐ Open ulcers
- ☐ Gangrene
- ☐ Discolored or blue skin
- ☐ Hemophilia (Bleeding Disorder)
- ☐ Lymphedema (Swelling in legs or arms)
- ☐ Deep Vein Thrombosis (Blood clot in leg)
- ☐ Peripheral Arterial Disease (Problem with blood flow to you legs)
- ☐ Raynaud's Syndrome (Problem with blood flow to your fingers or toes)
- ☐ Scleroderma (Skin disorder)
- ☐ Rheumatoid Arthritis (Swelling of joints)
- ☐ Peripheral Venous Disease (Problem with blood vessels in your legs)
- ☐ Phlebitis (inflammation of the veins in your legs)

Extremities Continued:

- ☐ Peripheral Venous Disease (Problem with blood vessels in your legs)
- ☐ Phlebitis (inflammation of the veins in your legs)
- ☐ Gout (Pain in big toes)
- ☐ Peripheral Venous Disease (Problem with blood vessels in your legs)
- ☐ Phlebitis (inflammation of the veins in your legs)
- ☐ Gout (Pain in big toes)

Infectious Disease:

Exposed to or been recently diagnosed with… (circle one)

C-diff (Clostridium difficile)

YES NO MOVE TO NEXT COLLUM

Hepatitis

YES NO

HIV

YES NO

MRSA

YES NO

If you circled YES for any of the above, please explain:

_____

_____

_____

Medication / Allergy History

Are you currently taking Aspirin? ☐ Yes ☐ No

Please list all MEDICATIONS you take routinely (including current and previous chemotherapy):

Name of Medication	Dosage (mg)	How many times daily

Medication Allergies:

_____

_____

Other Allergies:

_____

_____

Immunizations:

When was your last flu shot? _____

When was your last pneumonia shot? _____

Have you received the Covid 19 Vaccination? _____

Demographic Information

Patient's Name: _____
Last First Middle Initial

Address: _____ City _____State _____Zip _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female

Home Phone: _____ Cell: _____ Work: _____

Social Security #: _____ Email Address: _____

Permissions: ☐ Home ☐ Mobile ☐ Work	*I grant permission to have voice and/or text messages which may contain personal health information left on the phones selected.*

Emergency Contact: _____ Phone #: _____

Relationship to Patient: _____

Release of Records:	*I hereby authorize Vascular Institute to disclose my medical records including information regarding my condition, treatment, imaging, and diagnosis to my emergency contact.*

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Occupation: ☐ Employed ☐ Retired ☐ Student: ☐ Full Time ☐ Part Time

In order for our healthcare practice to meet the qualification requirements under the American Recovery and Reinvestment Act of 2009 we are required to obtain the following information:

1. Ethnicity ☐ Hispanic or Latino/a ☐ Non-Hispanic ☐ Do not wish to respond

2. Race: ☐ American Indian or Alaska Native ☐ Black or African American
   ☐ Asian ☐ White ☐ Other Race
   ☐ Native Hawaiian or Other Pacific Island ☐ Hispanic ☐ Do not wish to respond

3. Language: ☐ English ☐ Other: _____

List Preferred Pharmacy

Pharmacy Name: _____ Location: _____

Phone Number: _____ Fax: _____

Physician Information

Primary Care Physician

Physician Name: _____ Location: _____

Office Phone: _____ Fax: _____

Referring Physician

Physician Name: _____ Location: _____

Office Phone: _____ Fax: _____

Additional Physicians

Cardiologist:

Physician Name: _____ Location: _____

Office Phone: _____ Fax: _____

Specialty: _____

Physician Name: _____ Location: _____

Office Phone: _____ Fax: _____

Specialty: _____

Physician Name: _____ Location: _____

Office Phone: _____ Fax: _____

Release of Records:	I hereby authorize Advanced Wound Institute to disclose my medical records including information regarding my condition, treatment, imaging, and diagnosis to the physicians above.

Insurance Information

Primary Insurance: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Policyholder's Name: _____

Date of Birth: _____ Phone: _____ Social Security#: _____

If different from patient:

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Phone#: _____

Secondary Insurance: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Policyholder's Name: _____

Date of Birth: _____ Phone: _____ Social Security#: _____

If different from patient:

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Phone#: _____

Responsible Party **- Person responsible for receiving the financial statements.**

☐ **SELF**

☐ **Other - Please complete information below**

Name:

_____

Last First Middle Initial

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone#: _____ Secondary Phone#: _____

Date of Birth: _____ Email Address: _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I authorize Advanced Wound Institute to release health/medical information of:

Patient's Full Name: _____ Date of Birth: _____

This information is to be released to:

Recipient: _____ Relationship to patient: _____

Phone Number: _____

Recipient: _____ Relationship to patient: _____

Phone Number: _____

Recipient: _____ Relationship to patient: _____

Phone Number: _____

I understand that the information I have agreed to release to the aforementioned party may include sensitive clinical information obtained during the dates listed below. These may or may not include treatment of substanceor other abuse, HIV, psychiatric disorders, sexually transmitted diseases, etc., unless herein except:

_____

This release includes all documents created by Advanced Wound Institute, such as but not limited to:

- Office, Chart & Progress Notes
- Ultrasound Reports
- All documents that Advanced Wound Institute has ordered on your behalf.

Covering records from:

- The date of its creation by Advanced Wound Institute, whether in the past or future.

I UNDERSTAND THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME. THIS AUTHORIZATION SHALL REMAIN IN EFFECT UNLESS OTHERWISE REVOKED.

Signature (person authorizing release): _____

Date of Signature: _____ Relationship to Patient: _____

Advanced Medical Directive and Power of Attorney

Do you have an Advance Medical Directive? ☐ Yes ☐ No *(You Must Check One)*

If yes, Name: _____

Phone: _____

Do you have a Healthcare Medical Power of Attorney? ☐ Yes ☐ No *(You Must Check One)*

If yes, Name: _____

Phone: _____

AGREEMENT TO RECEIVE WOUND CARE

Between _____ and _____
Patient Name Provider Name

I understand that I am being seen for wound care treatment in order to assist healing of my wound(s). This treatment is known to be effective only when provided on a regular basis. Lapses in my treatment, such as missed days or sporadic days, or failure to comply with the plan of care can result in this therapy becoming less effective or ineffective. Thus, I understand that in order for my treatment to be worthwhile, it is important that I receive treatment as scheduled and follow the treatment instructions provided.

Wound Care Services: Wound care treatment may include, but shall not be limited to sharp debridement, dressing changes, biopsies, skin grafts, off-loading, Negative Pressure therapy and compression devices.
Risks/Side Effects: May include, but not be limited to: infection, ongoing pain and inflammation, potential scarring, possible damage to blood vessels or surrounding areas such as organs and nerves, bleeding, allergic reaction to medications, removal of healthy tissue, prolonged healing or failure to heal.
Patient Identification and Wound Images: Patient understands and consents that images (digital, film, etc.), may be taken of Patient and all Patient's wounds with their surrounding anatomic features. Patient further agrees that their referring physician or other treating physicians may receive communications, including these images, regarding Patient's treatment plan and results. The images are considered part of the medical record and will be handled in accordance with federal laws regarding the privacy, security, and confidentiality of such information. Patient understands that Advanced Wound Institute will retain the ownership rights to these images, but that the patient will be allowed access to view them or obtain copies. Patient understands that these images will be stored in a secure manner that will protect privacy and that they will be kept for the time period required by law. Patient waives any, and all rights to royalties or other compensation for these images. Images that identify the Patient will only be released and/or used outside Advanced Wound Institute upon written authorization from the Patient or Patient's legal representative.

I agree to be an active participant in my care. _____

Signature Date

Insurance and Payments

Financial Responsibility: Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurance carrier will be your responsibility, except as limited by our specific network agreement with your insurance carrier, if such an agreement is in place.

If you do not have health insurance, or if your health insurance will not pay for services rendered by us or if you notify us not to contact or bill your insurance company, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available at our front desk). Payment is due in full at the time of service.

By initialing this section, you acknowledge that you have received a copy of our Financial Policies to review. A copy is available at our front desk and online at: www.healmywounds.com	Initial:

Additional Notifications

Notice of Privacy Practice	
By initialing this section, I acknowledge that I have received a copy of the Notice of Privacy Practice which includes a Statement of Patient's Rights to review. A copy is available at our front desk and online at: www.healmywounds.com	Initial:

Code of Conduct	
By initialing this section, I acknowledge that I have received a copy of the Code of Conduct Statement to review. A copy is available at our front desk and online at: www.healmywounds.com	Initial:

Use of Media	
By initialing this section, I acknowledge that I have received a copy of the Use of Media statement to review. A copy is available at our front desk and online at: www.healmywounds.com	Initial:

By signing below, I voluntarily consent to all medical and surgical treatment performed by Advanced Wound Institute (I also consent to routine services, diagnostic procedures, medical treatment, other health care services deemed necessary by the health care providers treating me. I understand that the practice of medicine and surgery is not an exact science, and that diagnosis and treatment may cause injury or even death. I understand that I have a right to consent or to refuse to consent to any proposed surgery, procedure, or treatment, and to discuss it with my health care provider. I understand that if an employee or any individual associated with Advanced Wound Institute is exposed to my blood or bodily fluids, I will be tested for hepatitis viruses and the Human Immunodeficiency Virus (HIV).

The information on this form is accurate to the best of my knowledge.

Signature of Patient / Legally Authorized Representative _____ Date _____

Printed Name of Patient / Legally Authorized Representative _____ Relationship to Patient _____