



WOUND HEALING AND HYPERBARIC MEDICINE CENTER
 1119 HIGHLAND AVE. STE 7
 CLARKSTON, WA 99403
 (509) 758-1119 FAX (509) 758-1140

Please fill out the following forms so that we can best serve your needs. The Patient Information Form will help the doctor find the most effective strategies to help you get better. This form and the Authorization to Release Medical Records will help us keep accurate records of your care while you are here. So complete the forms and bring them with you to your first appointment. If you are unsure of an answer leave the space blank and talk to one of us when you come in. Thanks! The Wound Care Team.

DATE _____

NAME _____

ADDRESS _____

PHONE _____ CELL _____

DATE OF BIRTH _____ S.S.# _____

MARITAL STATUS (circle one) S M D W

EMERGENCY CONTACT PERSON _____

Phone 1 _____ Phone 2 _____

Address _____

Relationship _____

NEXT OF KIN _____

Phone 1 _____ Phone 2 _____

Address _____

Relationship _____

EMPLOYER _____ PHONE _____

WAS THIS DUE TO AN ACCIDENT? Y N DATE _____

PLACE _____

PRIMARY INSURANCE _____ POLICY # _____

SECONDARY INSURANCE _____ POLICY # _____

OTHER INSURANCE _____ POLICY # _____

PERSON RESPONSIBLE FOR ACCOUNT _____

REFERRING PHYSICIAN _____

PRIMARY PHYSICIAN _____

Patient Information Form (complete both sides of this form)

*This document should be attached to the patient's admitting H&P

Date:			
Social History		Family History	
Birthplace:		Have any, blood relatives had any of the following:	
		Circle Y or N	If Y, list relationship
Nationality:		Diabetes Y N	
Religion:		High blood pressure Y N	
Occupation:		Heart attack Y N	
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married	Stroke Y N	
	<input type="checkbox"/> Separated	Migraines Y N	
Living with	<input type="checkbox"/> Alone <input type="checkbox"/> Spouse	Diabetes Y N	
	<input type="checkbox"/> Children <input type="checkbox"/> Other	Cancer Y N	
		Dementia Y N	
Have you ever used: (Check all applicable)		Identify any other health problems in your family:	
<input type="checkbox"/> Intravenous drugs			
<input type="checkbox"/> Amphetamines			
<input type="checkbox"/> Cocaine			
<input type="checkbox"/> Marijuana			
<input type="checkbox"/> Tobacco	Quit when? _____		
<input type="checkbox"/> Alcohol			
<input type="checkbox"/> Tranquilizer or anti-psychotic			

Attending Physician Notes:

Current Medications	Dose	Allergies

Medical History: Have you ever had:

High blood pressure	Y N	Seizures	Y N	Thyroid trouble	Y N
Diabetes	Y N	Migraine headaches	Y N	Miscarriages	Y N
High cholesterol	Y N	Polio	Y N	Pregnancy	Y N
Heart attack	Y N	Osteoporosis	Y N	Menopause	Y N
Stroke	Y N	Gout	Y N	Tonsillectomy	Y N
Blood clots in leg	Y N	Arthritis	Y N	Appendectomy	Y N
Heart failure	Y N	Stomach ulcers	Y N	Hysterectomy	Y N
Blood transfusion	Y N	Gallbladder problems	Y N	Prostate surgery	Y N
Asthma	Y N	Pancreatitis	Y N	Coronary bypass	Y N
Emphysema	Y N	Hepatitis	Y N	Head injury	Y N

Medical History continued.

Have you ever had:

Tuberculosis	Y	N	Kidney failure	Y	N	Other:	
Cancer	Y	N	Kidney stones	Y	N		
Chemotherapy	Y	N					

Please provide additional information on any Yes answers to the above questions

Attending Physician Notes:

Review of Systems: Do you currently have or have you recently had the following:

General		Cardiac		Neurological	
Fatigue	Y N	Irregular heart beat	Y N	Headaches	Y N
Weight changes	Y N	Fainting/Blackouts	Y N	Weakness	Y N
Fever / night sweats	Y N	Chest pain	Y N	Numbness	Y N
Sensitivity to heat	Y N	Swelling of ankles	Y N	Memory Problems	Y N
Sensitivity to cold	Y N	Respiratory		Trouble sleeping	Y N
Poor appetite	Y N	Shortness of breath	Y N	Seizures	Y N
Skin		Coughing	Y N	Pain in Limbs	Y N
Rash	Y N	Coughing up blood	Y N	Imbalance	Y N
Itching	Y N	Wheezing	Y N	Psychological	
New growth	Y N	Digestive		Depression	Y N
Eyes		Pain	Y N	Anxiety	Y N
Trouble seeing	Y N	Bleeding	Y N	Genitourinary	
Uses glasses	Y N	Nausea / vomiting	Y N	Lack of sex drive	Y N
Ears, Nose, Throat		Constipation	Y N	Pain on urination	Y N
Hearing loss	Y N	Diarrhea	Y N	Difficulty urinating	Y N
Nose bleeds	Y N	Musculo-Skeletal		Frequent urination	Y N
Sore throat	Y N	Back pain	Y N	Breast	
Cold	Y N	Joint pain	Y N	Lumps	Y N
Trouble swallowing	Y N	Leg cramps	Y N	Discharge	Y N
Ringling in ears	Y N			GYN-OB	
				Pregnant	Y N
				Abnormal bleeding	Y N
				Missed menstrual period	Y N

Attending Physician Notes:

Signature and title of person completing above information:	
Date form completed:	
Residents Signature (if applicable):	
Date Signed:	
Attending Signature*:	
Date Signed:	

*The signature of the Attending physician confirms that he/she has verified the above information with the patient.



Authorization to Release Medical Health Care Information
Wound Healing and Hyperbaric Medicine Center

The HIPAA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers, law enforcement, and public health reporting. Please provide all family members or friends you want us to be able to speak with. Spouses are not automatically included: their names must be explicitly stated below. You may opt out by checking the "Do Not Release Information" box below.

Authorization to speak with family/friend (including spouse)
I give the following named person(s) authorization to take messages or speak with the staff and/or representatives of the Wound Healing Center on my behalf regarding:
Circle items authorized
APPOINTMENT FINANCIAL MEDICAL INSURANCE OTHER(explain)_____
Name of authorized person_____relationship_____
Name of authorized person_____relationship_____
Name of authorized person_____relationship_____
Name of authorized person_____relationship_____
Authorization to leave health information by alternate means_____
The Wound Healing Center will use any and all numbers provided by patient on the patient registration form to leave messages on voice mail for reminder calls and other patient information.

Initials

_____ I HAVE READ AND UNDERSTAND THIS RELEASE FORM

_____ DO NOT RELEASE INFORMATION TO ANYONE

I understand that my expressed consent is required to release any health information relating to testing, diagnosis and/or treatment for HIV(AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, if I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, I must specifically authorize the release of this information relating to such diagnosis, testing or treatment.

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider (s) should I wish to change one or more contacts listed above.

Patient's Name _____ Date of Birth _____
Please Print

Signature of patient or patients authorized representative

Relationship or status by anyone other than patient (parent, legal guardian, personal representative)