ST. VINCENT'S
HEALTHCARE

Patient Information

Patient's Name: _____
First Name Middle Name Last Name

Social Security #: _____ Date of Birth: _____
(Used for billing purposes only)

Ethnicity/Race: _____ Religion: _____

Patient Address: _____
City State Zip Code

Phone #: _____ Secondary Phone #: _____

Email: _____ How Did You Hear About Our Services: _____

Referring Physician: _____ Primary Care Physician: _____

Pharmacy: _____

Emergency Contact

First Name: _____ Last Name: _____

Relationship to Patient: _____ Contact #: _____

Caregiver and Home Health Information

Caregiver Contact Information:
First Name: _____ Last Name: _____ Phone#: _____
Home Health Contact Information:
Home Health Nurse: _____ Home Health Company: _____

Insurance Information

Primary Insurance Payer: _____ Is the Patient the Policy Holder: Yes or No

Name of Subscriber: _____ DOB: _____ Relationship of Subscriber to Patient: _____

Subscriber ID#: _____ Group Name: _____ Group #: _____

Secondary Insurance Payer: _____ Is the Patient the Policy Holder: Yes or No

Name of Subscriber: _____ DOB: _____ Relationship of Subscriber to Patient: _____

Subscriber ID#: _____ Group Name: _____ Group #: _____

Patient Signature: _____ **Date:** _____

Patient Representative: _____ **Relationship:** _____ **Date:** _____

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Allergies

If you can provide a list of all allergies, please circle: SEE COMPLETED LIST ATTACHED

Allergy: _____ Reaction: _____ Severity: Severe / Moderate / Mild

Allergy: _____ Reaction: _____ Severity: Severe / Moderate / Mild

Allergy: _____ Reaction: _____ Severity: Severe / Moderate / Mild

Current Medications

If you can provide a list of all medications, please circle: SEE COMPLETED LIST ATTACHED

Medication: _____ Route: _____ Strength: _____

Medication: _____ Route: _____ Strength: _____

Medication: _____ Route: _____ Strength: _____

Medication: _____ Route: _____ Strength: _____

Medication: _____ Route: _____ Strength: _____

Medication: _____ Route: _____ Strength: _____

Medication: _____ Route: _____ Strength: _____

Surgical History

If you can provide a list of all surgical history, please circle: SEE COMPLETED LIST ATTACHED

Surgeries: _____ Date: _____ Comments: _____

Surgeries: _____ Date: _____ Comments: _____

Surgeries: _____ Date: _____ Comments: _____

Surgeries: _____ Date: _____ Comments: _____

Other Active Diagnosis

Please check any current diagnosis:

1. MRSA (Methicillin-Resistant Staphylococcus Aureus) _____ Date of Diagnosis: _____
2. C. Difficile_____ Date of Diagnosis: _____
3. VRE (Vancomycin Resistant Enterococci) _____ Date of Diagnosis: _____
4. Tuberculosis_____ Date of Diagnosis: _____
5. Meningococcal Meningitis_____ Date of Diagnosis: _____
6. Mumps, Measles or Rubella_____ Date of Diagnosis: _____
7. Influenza _____ Date of Diagnosis: _____
8. AIDS/HIV with respiratory symptoms (i.e. cough, chest pain etc.) _____ Date of Diagnosis: _____

Office use only: Initial for isolation precautions
Employee Initials:_____ Date:_____

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Social History

Smoking Status (Circle One): Everyday Former Never

Please check all that apply:

- ☐ Assisted Living
- ☐ Alcohol Use
- ☐ Caffeine Use
- ☐ Children
- ☐ Cultural, Religious, or Language Concerns
- ☐ Retired
- ☐ Food, Clothing, or Shelter Needs
- ☐ SNF
- ☐ Substance Abuse
- ☐ Support Systems Lacking
- ☐ Illicit Drug Use
- ☐ In Counseling
- ☐ Long-term care facility
- ☐ Mental health concerns
- ☐ Object to Blood Products
- ☐ Homeless
- ☐ Transport Concerns
- ☐ Tobacco Use
- ☐ Unable to Care for Self

Advanced Directive

Please complete all that apply:

Do you have an Advanced Directive? _____Yes _____No

Who is your Durable Power of Attorney? Name: _____ Relationship to patient: _____

Would you like us to provide more information regarding Advance Directives? _____Yes _____No

I acknowledge that I had an opportunity to record with Advanced Wound Care & Hyperbaric Specialists, PC my current prefer preference for advanced directives. I understand that the physician(s) and care providers are not responsible for administering advance directives as to which Advanced Wound Care & Hyperbaric Specialists, PC has not been specifically and properly been notified.

Patient Signature/ Legal Representative: _____ **Date:** _____

Office use only: Inability to Obtain Patient Acknowledgement

We attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practice*, but acknowledgement could not be obtained, due to:

Circle best description situation below:

Individual Refused to Sign Unable to sign Emergency Other: _____

Employee Signature:_____ **Date:**_____

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HEALTHCARE

Medical History

Please check all that apply:

Condition:	Patient:	Mother:	Maternal Grandparents:	Father:	Paternal Grandparents:	Siblings:
Unknown History						
Cancer						
Diabetes						
Heart Disease						
Hypertension						
Kidney Disease						
Lung Disease						
Mental Illness						
None						
Other						
Seizures						
Stroke						
Thyroid Problems						
Tuberculosis						
Non-Contributory						

Nutrition Evaluation

Please circle all that apply:

Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties? **Yes / No / Unknown**

Have you had any weight loss during the last 3 months? **Yes / No / Unknown**

Have you suffered psychological stress or acute disease in the past 3 months? **Yes / No / Unknown**

Have you experienced neuropsychological problems? **Yes / No / Unknown**

What is your Height? _____ What is your Weight? _____

Fall Risk Evaluation

Please check all that apply:

Ambulatory aid: (do you rely on any of the following)

_____None
_____Bed rest
_____Nurse Assistance
_____Crutches / Cane / Walker / Other

Gait: (while walking/sitting)

_____Normal
_____Bed Rest
_____Wheelchair
_____Weak or impaired

ST. VINCENT'S
WOUND CARE AND
HYPERBARIC CENTER

INFORMED CONSENT FOR IMAGING

I, _____ (patient name), hereby consent that photographs/video may be taken of me by RestorixHealth in connection with the (hospital name), while I am receiving care at the wound care center.

Such photographs/videos may be published, shown, exhibited or otherwise used by RestorixHealth and its authorized affiliate for authorized educational or promotional activities.

I, _____, understand that neither I nor members of my family will be identified by name in connection with any public use of this material.

I, _____, grant this voluntary consent and I waive any rights for compensation in connection with any such use.

I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing.

Patient/Authorized Signature	Date	Relationship to Patient
Witness Signature	Date	Time