advanced WOUNDCARE & Hyperbaric Medicine of Michigan

Patient Demographics

Identification Information

Patient #: _____

First Name:_____

Middle Initial:_____

Last Name: _____

SSN: _____ DOB: _____

Sex: _____ Female _____Male Race:_____

Ethnicity: _____ Religion: _____

Preferred Language: _____

Preferred Confidential Communication: _____

Address 1: _____

Address 2: _____

City: _____

State: _____

Zip: _____

Phone: _____

Secondary Phone: _____

Email: _____

Care Center: _____

Admission Information

Consult: No / Yes
Medicare Admission: No / Yes
Non-Wound Diagnosis: No / Yes

Referral Source: _____

Inquiry Date: _____

Care Providers & Instructions

Wound Care Physician:_____

Referring Physician:_____

Primary Care Physician:_____

Pharmacy

Name:_____

Phone: _____

Advanced Directive: No / Yes
Durable Power of Attorney for Healthcare: No / Yes
Name:_____

Do Not Resuscitate: No / Yes
Living Will: No / Yes
Copy Provided to Facility: No / Yes

Insurance Information

Insurance Payor 1:_____

Insurance Classification:_____

CoPay:_____ Is Patient Policy Holder:_____

Name of Insured:_____

Relationship of Insured:_____ Policy Number:_____

Group Name:_____ Group Number:_____

Insurance Payor 2:_____

Policy Number:_____ Group Number:_____

Family/Emergency Contact Information

First Name:_____

Last Name: _____

Relationship::_____

Phone: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Caregiver Information

Capable of Self Care: No / Yes
Caregiver: No / Yes
First Name:_____

Last Name: _____

Phone: _____

Home Health Information

Company Name:_____

Nurse: _____

Phone: _____ Fax: _____

The above information is accurate and complete to the best of my knowledge. I understand that I have an obligation to provide Advanced Wound Care & Hyperbaric Medicine of Michigan with any corrections or updates to this information as soon as they become known to me.

Patient/Guardian Signature: _____ **Date:** _____