Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your consent.

Initial Intake Form

Face-Sheet/MD Orders Received? ☐ Yes ☐ No **Date:**

Last Name:	**First Name:**	**MI:**	**Sex:**
Email:	**Home Address:**	**City/State:**	**Zip:**
Home Phone: ( )	**Cell Phone: ( )**	**SSN:**	**DOB:**

Primary Insurance:

Insurance Carrier: ______________________________
Insurance Plan: ________________________________
Policy #: _______________________
Group #: _______________________

Secondary Insurance:

Insurance Carrier: ______________________________
Insurance Plan: ________________________________
Policy #: _______________________
Group #: _______________________

Chief Complaint:
Please describe wound and relevant facts:
____
____

History of Present Illness

Location of the wound:

Abdomen ☐ Back ☐ Leg ☐ Other ______________

Onset of present wound: _________ _____________

Approx. wound size: ___________________

Have you been treated for this wound? Yes ☐ No ☐

If yes, describe treatment & length of time: ____

Appointment Details

Urgent? Yes ☐ No ☐

If yes, Telemedicine appointment within 24 hours:
_____________ (Date) ______________ (Time)

Appointment Reminder Preference:

☐ Text
☐ Email
☐ Phone

General Center Appointment Date & Time: ____________ @ __________ ☐ am ☐ pm