WEST COAST
Wound Center
(559) 825-1980

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.

New Patient Care Form

Date

Patient Information

Name: _____ **Phone:** (____ _) _____ **DOB:** _____

Referring Provider: _____ **Referring Provider Phone:** (____ _) _____

Primary Care Provider (PCP): _____ **PCP Phone:** (___ __) _____

Preferred Pharmacy Address: _____ **Pharmacy Phone:** (___ __) _____

Do you smoke? ☐ Yes ☐ No **Do you drink?** ☐ Yes ☐ No **Height:** _____ **Weight:** _____

History of Present Illness

Location of current wound:

Abdomen ☐ Back ☐ Leg ☐ Other _____

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

Previous history of other wounds? ☐ Yes ☐ No

Location of previous wound(s):_____

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

Approx. wound size: Size of a: _____

If yes, describe treatment & length of time: _____

Past Medical History

Have you ever had the following?

Asthma/Breathing Problems	☐ Y	☐ N	HIV/AIDS	☐ Y	☐ N
Arthritis	☐ Y	☐ N	Heart Murmur	☐ Y	☐ N
Bleeding/Clotting Disorder	☐ Y	☐ N	Pneumonia	☐ Y	☐ N
Blood Pressure Disorder	☐ Y	☐ N	Pulmonary Embolism	☐ Y	☐ N
Blood Transfusion	☐ Y	☐ N	Emphysema	☐ Y	☐ N
Cancer (Type _____)	☐ Y	☐ N	Stroke	☐ Y	☐ N
Diabetes	☐ Y	☐ N	Epilepsy	☐ Y	☐ N
High Blood Pressure	☐ Y	☐ N	Kidney Disease	☐ Y	☐ N
Leukemia	☐ Y	☐ N	Hepatitis	☐ Y	☐ N
Psoriasis	☐ Y	☐ N	Tuberculosis	☐ Y	☐ N
Congestive Heart Failure	☐ Y	☐ N	Rheumatoid Arthritis	☐ Y	☐ N
Gout	☐ Y	☐ N	Other: _____		

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Current Medications:

_____
_____
_____

Drug Allergies:

_____
_____
_____

Home Health Information:

Home Health (HH) Name: _____ Nurse's Name: _____

HH Phone: (_____) _____ HH Address: _____

General Consent for Care and Treatment

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to the care and treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

Your health information will be protected and stored in our database for purposes of education, billing, quality assessment and health operations. Your health information includes both medical and demographic information. Disclosure of your health information shall be in compliance with the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any tests ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be informed.

I consent to the care, treatment and services explained by the physician and consent to the use and disclosure of my health information as set forth in this document or as otherwise permitted by applicable laws, regulations and policies.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: _____

Print Name: _____ **Date:** _____

Relationship to patient: _____