Surgical Wound Care
ASSOCIATES

Left Blank
For Office Use Only

Identification

Name

_____
First Middle Last

Preferred Name _____ Legal Sex ☐ Male ☐ Female

Birthdate_____ Social Security _____

Mailing Address_____

City _____ State _____ Zip _____

Email _____ Marital Status ☐ S ☐ M ☐ W ☐ D

Home phone (____)____-_____ Mobile phone (____)____-_____

Language ☐ English ☐ Spanish ☐ Other _____ Race_____ Ethnicity _____

Gender Identity _____Pharmacy_____Phone_____

Emergency Contact

Name_____ Relationship _____

Home phone (_____)_____-_____ Mobile phone (_____)_____-_____

Insurance Information

Primary Insurance_____ Subscriber ID_____

Secondary Insurance_____Subscriber ID_____

Insurance Authorization and Assignment

I understand that I am financially responsible for any medical services at time of service. I authorize my insurance carrier to pay Surgical Wound Care Associates, PLLC, any assigned claims filed by them and authorization for release of medical information requested by my insurance company. For Medicare beneficiaries, I request payment of authorized Medigap benefits be made to me or on my behalf to Surgical Wound Care Associates of Arizona and medical information about me to be released to my Medigap insurer.

Signature_____Date_____
Witness_____

Minor/Parental Consent

Please note, whoever brings a child in to be seen is responsible for payment at time of service unless prior arrangements have been made. It is the custodial parent's responsibility to arrange reimbursement from a non-custodial parent. By signing below, I hereby give my consent to Surgical Wound Care Associates, PLLC to treat my minor child, under 18 years of age.

Signature_____Date_____

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Authorizations

I hereby authorize the following individuals, other than myself, to receive information regarding my healthcare, lab/diagnostic results, appointments and/or billing and collections. These individuals will be required to provide at least one of the following before any information is discussed with them: the last four (4) digits of my SSN#, my date of birth, or my address.

Name _____Relationship _____

Name _____Relationship _____

Acknowledgement of Receipt of Notice of Privacy Practices & Patient Rights

By signing this document, I acknowledge that I have reviewed and/or received a copy of the Notice of Privacy Practices and Patient Rights, which provides a more complete description of how my protected health information (PHI) may be used or disclosed. I understand that Surgical Wound Care Associates reserves the right to change their notice and information practices and that I may view a copy of the current Notice on Surgical Wound Care Associates website, www.swcaaz.com.com, in any of their offices, or by a request in writing.

Health Information Exchange Program

Surgical Wound Care Associates PLLC participates in the Health Information Exchange (HIE) program to increase collaboration with other healthcare practitioners to provide better care for patients. This program allows for the safe exchange of clinical patient information such as office notes, testing, laboratory results, etc. to help all practitioners provide accurate care/treatment in a timely manner and minimize redundant testing with extra expenses.

I _____ give permission for Surgical Wound Care Associates PLLC to participate on
(First and Last Name)
my behalf with the Health Information Exchange (HIE) program including Care Quality and Common Well.

Signature_____Date _____

Witness_____Date_____

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I authorize Surgical Wound Care Associates, PLLC to take pictures of my wounds for my treatment and place them in my clinical chart for reference purposes.
I authorize Surgical Wound Care Associates, PLLC to download my prescription history from Surescripts/RxHub and CSMD. I understand the prescription history will solely be used for medical purposes.
I authorize Surgical Wound Care Associates, PLLC to download my immunization history from TennIIS, the Tennessee Immunization Information System. I understand the history of immunization will solely be used for medical purposes.
I understand to give 24-hour advance notice if I am unable to keep my appointment. I understand a $25 fee may be incurred after the second missed appointment for not providing the office the prior notice of cancellation. After 3 no-show appointments in a calendar year, you may be discharged from the practice, at the discretion of the provider and management. Medical care will not be withheld
I understand all outstanding balances are due at the time of service or upon receipt of a statement. Any collection agency fees will be patient responsibility and will be added to your total balance due. Surgical Wound Care Associates PLLC reserves the right to discharge patients for delinquent financial account balances. For billing questions, you may reach our billing department Monday-Friday 8:00am-5:00pm at 423-449-8135 ext # 315.
I understand my health care team can be reached either by telephone or through the patient portal. It is not appropriate to communicate through social media or texting any provider or staff member personal number.
I understand our providers serve our patients 24 hours a day, 7 days a week. After normal business hours, the phones are answered by the answering service for emergencies.
I understand that prescription refills should be handled during your office visit. If refill requests are called in or sent through the patient portal, please allow 72 hours to be addressed before checking with your pharmacy. Monthly refills of any controlled medications (pain medication, etc.) will only be given during an office visit within regular business hours.
We participate with several insurance plans and will file your claims on your behalf. It is your responsibility to ensure coverage for services prior to your visit. All co-payments, deductibles or non-covered charges will be due at time of service.

Consent Policy:

By signing below, you attest that all the information provided is complete and accurate. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. I consent to receiving communications via telephone, mail, email, text messages and any electronically generated communications regarding my possible patient balance, billing, health records and upcoming appointments.

Patients Signature_____Date_____

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Medical History Form – Please Fill Out Completely

Last Name _____ First Name _____

Birthdate _____ Age _____ Height _____ Weight _____

Primary Care Provider _____ How did you hear about us? _____

Do you have, or are you being treated for any of the following? (Check all that apply)

□ High Blood Pressure	□ Pacemaker	□ Blood clots
□ Kidney Disease	□ Bleeding Problems	□ Asthma
□ Emphysema	□ Stomach/colon disease	□ Cancer
□ Diabetes	□ Ulcers	□ Hepatitis
□ Seizures	□ Stroke	□ HIV/AIDS
□ Heart Disease	□ Neuropathy	□ Other _____

If you have diabetes, who manages it? (Provider and Practice name) _____

List all previous surgeries. Use back if needed.

	Procedure	Date (Approximate)	Surgeon
1.			
2.			
3.			
4.			

Please list ALL medications, including non-prescriptions/supplements. Use back if needed.

	Name	Dose	Frequency		Name	Dose	Frequency
1.				**5.**			
2.				**6.**			
3.				**7.**			
4.				**8.**			

Preferred Pharmacy _____ **Phone number** (____)_____-_____

Are you currently receiving treatment at a pain clinic? □ Yes □ No

If yes, list name and phone number _____

Please list ALL medical allergies and reaction. □ None Latex Allergy □ Yes □ No

1.		**3.**	
2.		**4.**	

Do you have a living will? □ Yes □ No Highest grade completed _____

How much caffeine do you drink per day? _____

Stairs in home: □ Yes □ No Cane: □ Yes □ No Walker: □ Yes □ No Wheelchair: □ Yes □ No

Alcohol use: □ Yes □ No Number of drinks: ___ day ____week

Tobacco use: □ Yes □ No _____Cigarettes (pack/day) _____cigars/pipe per day _____dip/chew per day

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Family History (Check all that apply)

☐ Birth Defects	☐ Heart Disease	☐ Blood clots/bleeding problems
☐ High Blood Pressure	☐ Kidney Disease	☐ Cancer
☐ Asthma	☐ Stomach/Colon disease	☐ HIV/AIDS
☐ Emphysema	☐ Seizures	☐ Hepatitis
☐ Diabetes	☐ Stroke	☐ Other _____

Work

☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student

Type of work performed _____

Review of Systems – Have you had an RECENT problems with any of the following?

Constitutional	**Yes**	**No**
Recent Fever	☐	☐
Night Sweats	☐	☐
Weight Gain	☐	☐
Weight Loss	☐	☐
Exercise Intolerance	☐	☐

Genitourinary	**Yes**	**No**
Urinary Incontinence	☐	☐
Difficulty Urinating	☐	☐
Blood in Urine	☐	☐
Urinary Frequency	☐	☐
Incomplete Emptying	☐	☐

Endocrine	**Yes**	**No**
Fatigue	☐	☐
Increased Thirst	☐	☐
Hair Loss	☐	☐
Increased hair growth	☐	☐
Cold Intolerance	☐	☐

Eyes	**Yes**	**No**
Dry Eyes	☐	☐
Irritation	☐	☐
Vision Change	☐	☐

ENMT	**Yes**	**No**
Difficulty Hearing	☐	☐
Ear Pain	☐	☐
Frequent Nose Bleeds	☐	☐
Nose/Sinus Problem	☐	☐
Sore Throat	☐	☐
Bleeding Gums	☐	☐
Snoring	☐	☐
Dry Mouth	☐	☐
Mouth Ulcers	☐	☐
Oral Abnormalities	☐	☐

Musculoskeletal	**Yes**	**No**
Muscle Aches	☐	☐
Muscle Weakness	☐	☐
Joint Pain	☐	☐
Back Pain	☐	☐
Extremity Swelling	☐	☐

Integumentary	**Yes**	**No**
Abnormal mole/lesion	☐	☐
Jaundice	☐	☐
Rash	☐	☐
Itching	☐	☐
Dry skin	☐	☐

Neurologic	**Yes**	**No**
Loss of consciousness	☐	☐

Allergic/Immunologic		
Runny Nose	☐	☐
Sinus Pressure	☐	☐
Itching	☐	☐
Hives	☐	☐
Frequent Sneezing	☐	☐

Notes:

Teeth Problems	☐	☐	Weakness	☐	☐
			Numbness	☐	☐
Cardiovascular	**Yes**	**No**	Seizures	☐	☐
Chest Pain at rest	☐	☐	Dizziness	☐	☐
Chest pain with exertion	☐	☐	Headaches	☐	☐
Arm pain on exertion	☐	☐	Restless Legs	☐	☐
Short of breath - walking	☐	☐			
- lying down	☐	☐	**Psychiatric**	**Yes**	**No**
Heart Palpitations	☐	☐	Depression	☐	☐
			Sleep Disturbances	☐	☐
Gastrointestinal	**Yes**	**No**	Safe in Relationship	☐	☐
Abdominal Pain	☐	☐	Alcohol Abuse	☐	☐
Vomiting	☐	☐			
Vomiting blood	☐	☐	**Hematologic/ Lymphatic**	**Yes**	**No**
Change in appetite	☐	☐	Swollen Glands	☐	☐
Black/tarry stool	☐	☐	Easy Bruising	☐	☐
Diarrhea	☐	☐	Excessive bleeding	☐	☐

Signature_____

Date _____

Care Team

Please list any other providers and their specialties who are part of your care team: