Date: _____ Completed By: _____ Wound Care ☐ HBOT ☐

New Patient Form

Name: _____ Phone #_____DOB_____/_____ /_____

Insurance : _____ ID#: _____

City/State you are located: _____

Referrer: _____ Referring Physician Phone Number:_____

PCP Name: _____ PCP Phone Number: _____

Wound/Injury Type: Trauma ☐ Diabetic ☐ Surgical ☐ Pressure ☐ Venous ☐ other:_____

_____

_____

Wound/Injury location: _____

Time since/date of onset: _____ Days ☐ Weeks ☐ Months ☐ Years ☐

Previously treated: Yes ☐ No ☐ | If ***yes***, physician name and facility: _____

_____

_____

Are you a Diabetic: Yes ☐ No ☐ | If ***yes***, A1C in last three months: Yes ☐ No ☐

Vascular testing: Yes ☐ No ☐ | If ***yes***, how long ago: _____

Vascular disease: Yes ☐ No ☐ | If ***yes***, name & phone # of diagnosing physician: _____

_____

Ambulatory: Yes ☐ No ☐ | Walker ☐ Wheelchair ☐ _____

Able to transfer to exam chair: Yes ☐ No ☐

If ***no***, someone to assist them to the clinic: Yes ☐ No ☐

Are you in a Skilled Nursing Facility: _____ | Facility name: _____

Additional Information:

_____

_____