# Patient Information

*Please fill out forms entirely*

Name: DOB:

Phone: Alt Phone:

SSN: Marital Status:

Physical Address:

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient Portal Access: Y / N

Emergency Contact/relationship: Phone:

Relationship to Patient:

Race (circle): Hispanic/Latino American Indian/Alaska Native Black/African American Native Hawaiian/Pacific Islander White Asian Two or More Races Decline to State Other:

Ethnicity (circle): Hispanic/Latino Not Hispanic/Latino/Decline to State

Reason for Consultation:

Location of wound/duration:

Previous treatment:

Pharmacy: Address:

Referring Physician/Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Health Agency (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: Phone:

Appointment Reminder: \_\_\_\_\_Text \_\_\_\_\_Phone call \_\_\_\_\_Both

**Social History:**

\_\_\_ Current or Former Tobacco use

 If yes, type (circle): Smoke Vape Pipe Dip Chew Other

 If yes, how often and for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If former use, stop date: \_\_\_\_\_\_\_\_\_

\_\_\_\_Alcohol

If yes, how many drinks per week \_\_\_\_\_\_\_\_\_\_

**Past Medical History:**

\_\_\_\_Diabetes

 If yes, most recent A1C \_\_\_\_\_\_\_ Year diagnosed\_\_\_\_\_\_\_

\_\_\_\_Stroke

 If yes, when \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Heart Attack

 If yes, when \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Cancer

If yes, type and year diagnosed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History:**

\_\_\_\_Vascular surgery (veins or arteries)

 If yes, practice/surgeon and date of surgery \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Other surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

1. Primary Insurance Company:

Subscriber Name:

Subscriber DOB: Subscriber SSN:

Relationship to Subscriber (circle one): Self Spouse Child Other:

Subscriber ID #: Subscriber Group #:

1. Secondary Insurance Company:

Subscriber Name:

Subscriber DOB: Subscriber SSN:

Relationship to Subscriber (circle one): Self Spouse Child Other:

Subscriber ID #: Subscriber Group #:

*Please provide insurance card and photo identification for verification.*

**HIPPA Authorization**

I give permission for SWCA-AZ to RELEASE any medical information to:

Name:

*The above-mentioned person(s) will be required to provide photo ID when picking up items.*

**General Consent for Care and Treatment & Consent to Bill**

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).*

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 treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing.

You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare 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 asked to read and sign additional consent forms prior to the test(s) or procedure(s).

If I do not have medical insurance, I understand that I am responsible for all charges incurred and that I will be billed for any outstanding balances in accordance with SWCA-AZ billing policy.

If my insurance is accepted, I authorize payment of benefits to SWCA-AZ or will reimburse SWCA-AZ if I am paid directly by my carrier.

I hereby authorize that SWCA-AZ may furnish information concerning my illness and treatment to my insurance carrier(s) in accordance with its privacy policy.

I am advised that any tests (blood work and other specimens) sent to an outside laboratory will result in additional charges that will be billed to my insurance carrier and/or will be billed directly to me by the laboratory.

I also understand that I am responsible for any part of the charges that are not covered by my insurance and I will be billed directly for those services.

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

Printed Name: Relationship to Patient:

Signature: Date:

**Release of Patient Records**

Patient's Name: Date of Birth:

Previous Name: SSN #:

I request and authorize:

Name/Provider:

To release healthcare information of the patient named above to:

Name: SWCA-AZ
Address: 1415 Old Weisgarber Rd, Suite 350

City: Knoxville, TN 37909
Phone: 865.936.9480 Fax: 865.224.3200

This request and authorization will apply to other Doctors House Calls operation locations:

* Healthcare information relating to the following treatment, condition, or dates:
* All healthcare information

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Patient Name (Please Print) Relationship to Patient (if not self)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient Signature (or Responsible Party) Date

* THIS AUTHORIZATION IS IN EFFECT FOR THE DURATION OF YOUR TREATMENT.