

**Wound Care & Hyperbaric Oxygen Therapy Clinic Intake**

Phone (810)342-5500 • Fax (810)342-5545

G3200 Beecher Road • Suite O2 • Flint, MI 48532

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Language\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Durable power of attorney for health care: ❑ Yes ❑ No If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Service requested: ❑ Wound Care**  Location of wound:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duration\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is the wound a worker’s compensation claim? ❑ Yes ❑ No  Is the wound the result of an auto accident? ❑ Yes ❑ No If yes, date of accident\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Does the patient use a wheelchair? ❑ Yes ❑ No |

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| **Service requested: ❑ Hyperbaric Oxygen Therapy**  Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| --- | --- | --- | --- |
|  | Primary Insurance | Secondary Insurance | Tertiary Insurance |
| **Payer** |  |  |  |
| **Member** |  |  |  |
| **Policy #** |  |  |  |
| **Group #** |  |  |  |

**\*\*\*Demographics do not need to be filled in if you are including a face sheet with this order\*\*\***

|  |  |
| --- | --- |
| **PCP Name** | **Referring Name** |
| **Address** | **Address** |
| **City, State, Zip** | **City, State, Zip** |
| **Phone** | **Phone** |
| **Fax** | **Fax** |

**Please fill out all the above areas completely**

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| **Internal Office Use Only**  Appt Date & Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ❑ Established ❑ New MRN# HPP PT# |