PATIENT DEMOGRAPHIC & INSURANCE INFORMATION

First Name: _____ MI: _____ Last Name: _____

DOB: ____/____/_____ SSN: _____ Gender: ☐Male ☐ Female

Email: _____

Address_____ Apt#_____ City_____ State _____ Zip_____

Primary Phone (_____) _____ Secondary Phone (_____) _____

☐ Check if Policy holder same as Patient

Primary Insurance: _____ID#_____Group#_____

Policyholder's Name: _____ ☐ Check if Address same as patient

Policyholder's DOB: _____ SSN: _____

☐ Check if Policy holder same as Patient

Secondary Insurance: _____ID#_____Group#_____

Policyholder's Name: _____ ☐ Check if Address same as patient

Policyholder's DOB: _____ SSN: _____

Emergency Contact Name: _____ Relationship: _____

Phone: (_____) _____

Primary Care/Provider (PCP) Name: _____ PCP Phone: (_____) _____

Preferred Pharmacy Name: _____ Pharmacy Phone: (_____) _____

Pharmacy Address or Cross Streets: _____

COMPLETE FOR MINORS ONLY

Name of Person Responsible for this account: _____

Relation: _____ DOB: ____/____/____ SSN: _____

Phone: _____

How did you hear about Rapid Care Centers? Check all that apply:

☐Online ☐ Drive by ☐Friend/Family ☐ Event ☐Flyer ☐Other Advertising

Date: _____

HISTORY & PHYSICAL

GENERAL INFORMATION	
PRIMARY CARE PHYSICIAN:	PHONE:
REFERRING PHYSICIAN:	PHONE:
HOME HEALTH COMPANY:	PHONE:
CARE FACILITY:	PHONE:

WOUND INFORMATION
WHERE IS YOUR WOUND?
WHEN DID YOUR WOUND START?
HOW DID YOUR WOUND START?
IS THIS A RECURRING WOUND?
PHYSICIANS THAT HAVE CARED FOR YOUR WOUND:
TYPES OF DRESSINGS USED?

SURGERIES/INVASIVE PROCEDURES	
TYPE/YEAR	TYPE/YEAR
1.	5.
2.	6.
3.	7.
4.	8.

SOCIAL HISTORY
TOBACCO USE: NEVER PREVIOUS CURRENT TYPE: PACKS PER DAY: YEARS USED:
ALCOHOL USE: NEVER PREVIOUS CURRENT TYPE: DRINKS PER DAY: YEARS USED:
RECREATIONAL DRUG USE: NEVER PREVIOUS CURRENT TYPE: YEARS USED:
DO YOU LIVE ALONE? YES NO DO YOU HAVE SOMEONE AVAILABLE TO HELP YOU? YES NO

WOUND PAIN
IS YOUR WOUND PAINFUL? YES NO WHAT IS YOUR CRRRENT WOUND PAIN LEVEL (0-10)?
HOW WOULD YOU DESCRIBE YOUR PAIN? BURNING STABBING THROBBING OTHER:
HOW IS YOUR WOUND PAIN RELIEVED? MEDICATION ELEVATION DANGLE OTHER:

MEDICAL HISTORY

PLEASE INDICATE IF YOU OR ANY OF YOUR FAMILY MEMBERS HAVE BEEN DIAGNOSED WITH THE FOLLOWING CONDITIONS:

CONDITION	PATIENT	FAMILY	EXPLAIN (WHO, AGE)
ASTHMA			
AUTOIMMUNE DISEASE TYPE:			
BLEEDING DISORDER TYPE:			
CANCER TYPE:			
CIRCULATION PROBLEMS (PVD, PAD)			
CONGESTIVE HEART FAILURE (CHF)			
CORONARY ARTERY DISEASE (CDF)			
DEEP VEIN THROMBOSIS (DVT)			

DEMENTIA			
DEPRESSION/ANXIETY			
DIABETES TYPE:			
EMPHYSEMA OR COPD			
HEPATITIS TYPE:			
HIGH BLOOD PRESSURE (HYPERTENSION)			
HIGH CHOLESTEROL (HYPERLIPIDEMIA)			
HIV/AIDS			
KIDNEY DISEASE (RENAL FAILURE)			
LYMPHEDEMA			
NEUROPATHY			
THYROID DISEASE			
RHEUMATOID ARTHRITIS			
OTHER:			

MEDICATION LIST

PHARMACY: _____ PHONE: _____

ALLERGIES	
1.	4.
2.	5.
3.	6.

MEDICATIONS
(Including over-the-counter & herbal preparations)

MEDICATION	DOSE	FREQUENCY	REASON
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			