Anchor Restorative Medicine Wound Care Patient Intake Form (2 pages)

Patient Information:

- **Full Name:** _____
- **Date of Birth:** _____
- **Gender:** _____
- **Address:** _____
- **City:** _____ **State:** _____ **ZIP Code:** _____
- **Phone Number:** _____
- **Email Address:** _____
- **Primary Language:** _____
- **Do you need an interpreter? ☐ Yes ☐ No**

Emergency Contact:

- **Name:** _____
- **Relationship:** _____
- **Phone Number:** _____

Insurance Information:

- **Primary Insurance Provider:** _____
- **Policy Number:** _____
- **Group Number:** _____
- **Secondary Insurance Provider:** _____
- **Policy Number:** _____
- **Group Number:** _____

Primary Care Physician:

- **Name:** _____
- **Phone Number:** _____

Wound Information:

- **Type of Wound: ☐ Pressure ☐ Diabetic ☐ Vascular ☐ Traumatic ☐ Post-operative ☐ Other:** _____

- **Location of Wound: _____**
- **How long have you had the wound? _____**
- **Previous Treatments: _____**
- **Current Wound Care Products Used: _____**
- **Any known allergies to wound care products? ☐ Yes ☐ No**
    - **If yes, please list: _____**

Medical History:

- **Do you have any of the following conditions? (Check all that apply)**
    - **☐ Diabetes**
    - **☐ Hypertension**
    - **☐ Heart Disease**
    - **☐ Kidney Disease**
    - **☐ Peripheral Arterial Disease**
    - **☐ Other: _____**
- **Current Medications: _____**
- **Previous Surgeries: _____**
- **Do you smoke? ☐ Yes ☐ No**
- **Do you consume alcohol? ☐ Yes ☐ No**

Additional Information:

- **How did you hear about Anchor Restorative Medicine?**
  _____
- **Do you require financial assistance for your care? ☐ Yes ☐ No**
    - **If yes, please provide your email to receive information on Texas's patient assistance programs: _____**

Consent and Acknowledgment: I hereby consent to the treatment provided by Anchor Restorative Medicine and acknowledge that the information provided above is accurate to the best of my knowledge. I understand that my health information will be used and protected in accordance with HIPAA regulations.

- **Patient Signature: _____**
- **Date: _____**