Charleston
Wound Care

New Patient

Date: _____

We are pleased to welcome you to Charleston Wound Care. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to assist you.

Patient Information

Last Name _____ First Name _____ Middle Initial _____
Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____
Mailing Address (if different) _____ Email Address _____
Social Security # _____ Driver's License # _____
Sex ☐ M ☐ F Age ____ Birthdate ____/____/____ Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced
Patient Employed By _____ Occupation _____
May we call you at work? ☐ Yes ☐ No Work Phone _____
Emergency Contact _____ Relationship to Patient _____
Home Phone _____ Cell Phone _____ Work Phone _____
Pharmacy _____ Phone # _____
Pharmacy Address _____ City _____ State _____ Zip _____

Insurance Information

Primary Insurance

Insurance Company _____ Phone # _____
Contract # _____ Group # _____ Subscriber # _____
Person responsible for account _____ DOB _____/_____/_____
Relation to Patient _____ Social Security # _____ DOB _____/_____/_____
Address (If different than patient) _____
Person responsible employed by _____ Occupation _____
Business Address _____ Business Phone _____

Secundary Insurance

Insurance Company _____ Phone # _____
Contract # _____ Group # _____ Subscriber # _____
Person responsible for account _____ DOB _____/_____/_____
Relation to Patient _____ Social Security # _____ DOB _____/_____/_____
Address (If different than patient) _____
Person responsible employed by _____ Occupation _____
Business Address _____ Business Phone _____

Additional Insurance

Insurance Company _____ Phone # _____
Contract # _____ Group # _____ Subscriber # _____
Person responsible for account _____ DOB _____/_____/_____
Relation to Patient _____ Social Security # _____ DOB _____/_____/_____

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the physician to help determine appropriate treatment. If there is any change in my medical status, I will inform the physician. I authorize my insurance company to pay the physician or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this information on all insurance submissions. I authorize the physician to release all information necessary to secure the payment of benefits. I understand that if I am in default of payment, I will be responsible for any attorney or collections fees. This authorization is valid for the duration of my treatment at Charleston Wound Care.

Signature _____ Date _____

PATIENT AGREEMENT

I understand that payment is due at the time of service, including copays and/or deductible. I certify that the information provided on this form is correct. I authorize the release of information including medical information to this organization and all insurance organizations involved with my claim. I understand that if I am in default of payment, I will be responsible for any attorney or collections fees. I authorize my physician to prescribe medication and to give me reasonable and proper medical care by today's standards. This authorization is valid for the duration of my treatment at Charleston Wound Care.
Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I choose) and understand the Notice.
Patient Signature _____ Date _____
Parent or Authorized Representative (if applicable) _____

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Charleston Wound Care for any services furnished me by the physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services. This authorization is valid for the duration of my treatment at Charleston Wound Care.

Signature _____ Date _____

MEDICARE SECONDARY INSURANCE

I understand that my secondary claim is billed as courtesy only and will be submitted to the appropriate party ONE TIME. After that one-time submission of the insurance company does not pay within 60 days or denies the claim, I (the patient) will be financially responsible to pay. This authorization is valid for the duration of my treatment at Charleston Wound Care.

Signature _____ Date _____

DISCUSSION OF MEDICAL TREATMENT

List the family members or other persons, if any, with whom we can discuss your medical diagnosis and treatment.

Name: _____ Relationship to you: _____
Name: _____ Relationship to you: _____
Name: _____ Relationship to you: _____
Name: _____ Relationship to you: _____
Name: _____ Relationship to you: _____