

History and Physical

Name: _____ DOB: _____ Chart Number: _____

- Medical History:**
- | | | | | | |
|---|--|--|---|--|---|
| <input type="checkbox"/> Liver | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Breathing issues |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Gout | <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Blood clot | <input type="checkbox"/> Stomach/bowel | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Neuropathy (specify) _____ | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | |
| <input type="checkbox"/> Arthritis (specify) _____ | <input type="checkbox"/> Thyroid disease (specify) _____ | <input type="checkbox"/> Diabetes (type 1, type 2) | <input type="checkbox"/> HIV | <input type="checkbox"/> CVA | |
| <input type="checkbox"/> other (specify) _____ | <input type="checkbox"/> Skin disorders | <input type="checkbox"/> Stroke | | | |
- Are you pregnant?** Yes No **Are you nursing?** Yes No

- Surgical History** None Appendectomy C-Section Angioplasty Bypass Cataracts Cholecystectomy
- Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? Yes No
- If yes, please describe: _____
- Do you have any artificial joints? Yes (where? _____) No Do you have an artificial heart valve? Yes No

- Social History**
- Do you smoke? Yes No If yes how many packs per day? 1 2 3 4 5 For how long? _____
- Do you drink alcohol? Yes, everyday (5-7 days/week) Yes, occasionally/socially No/Rarely
- Substance abuse: Yes, I have a current substance abuse problem. Please specify: _____
- Yes, I had a past substance abuse problem. Please specify: _____
- No, I have never had a substance abuse problem
- What is your occupation? _____ Does it involve mostly standing or sitting
- Do you exercise regularly? No, I do not exercise regularly Yes, I do the following regular exercise: _____

- Family History** Is there any family history (blood relative) of: (Please indicate family member)
- | | |
|---|--|
| <input type="checkbox"/> Alzheimer's _____ | <input type="checkbox"/> Depression _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Bleeding disorders _____ | <input type="checkbox"/> Emphysema _____ |
| <input type="checkbox"/> Blood clot _____ | <input type="checkbox"/> Heart disease _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Cataracts _____ | <input type="checkbox"/> Neurological _____ |
| <input type="checkbox"/> Circulation problems _____ | <input type="checkbox"/> Strokes _____ |
| <input type="checkbox"/> Other (specify): _____ | |

- Review of Systems** (Please check the box if you currently have any of these symptoms or check "NONE")
- | | | | | | |
|-------------------------|--|--|--|--|---|
| Cardiovascular | <input type="checkbox"/> leg pain when walking | <input type="checkbox"/> fever | <input type="checkbox"/> chest pain/pressure | <input type="checkbox"/> leg swelling | <input type="checkbox"/> cold hands/feet |
| | <input type="checkbox"/> fainting | <input type="checkbox"/> palpitations | <input type="checkbox"/> vascular disease | <input type="checkbox"/> valve problems | <input type="checkbox"/> NONE |
| Genitourinary | <input type="checkbox"/> blood in urine | <input type="checkbox"/> hesitancy | <input type="checkbox"/> incontinence | <input type="checkbox"/> increased urgency | |
| | <input type="checkbox"/> decreased frequency | <input type="checkbox"/> excessive urination | <input type="checkbox"/> kidney disease | <input type="checkbox"/> kidney stones | <input type="checkbox"/> NONE |
| Gastrointestinal | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> heartburn | <input type="checkbox"/> blood in stool | <input type="checkbox"/> vomiting | <input type="checkbox"/> ulcers |
| | <input type="checkbox"/> diarrhea | <input type="checkbox"/> trouble swallowing | <input type="checkbox"/> decrease appetite | <input type="checkbox"/> increase appetite | <input type="checkbox"/> constipation |
| Integumentary | <input type="checkbox"/> athlete's foot | <input type="checkbox"/> nail abnormalities | <input type="checkbox"/> keloids | <input type="checkbox"/> itchiness | <input type="checkbox"/> dry, scaly skin |
| | | | | | <input type="checkbox"/> NONE |
| Hematologic | <input type="checkbox"/> lower leg ulcers | <input type="checkbox"/> sickle cell disease | <input type="checkbox"/> anemia | <input type="checkbox"/> blood thinners | <input type="checkbox"/> clotting disorders |
| | | | | | <input type="checkbox"/> NONE |
| Neurological | <input type="checkbox"/> tingling | <input type="checkbox"/> weakness | <input type="checkbox"/> seizures | <input type="checkbox"/> numbness | <input type="checkbox"/> headaches |
| | <input type="checkbox"/> tremors | <input type="checkbox"/> paralysis | | | <input type="checkbox"/> NONE |
| Musculoskeletal | <input type="checkbox"/> back pain | <input type="checkbox"/> joint swelling | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> muscle pain | <input type="checkbox"/> neck pain |
| | <input type="checkbox"/> sciatica | <input type="checkbox"/> joint stiffness | <input type="checkbox"/> joint pain | <input type="checkbox"/> joint instability | <input type="checkbox"/> arthritis |
| | | | | | <input type="checkbox"/> NONE |
| Respiratory | <input type="checkbox"/> chest pain | <input type="checkbox"/> wheezing | <input type="checkbox"/> COPD | <input type="checkbox"/> coughing | <input type="checkbox"/> snoring |
| | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> emphysema | | | <input type="checkbox"/> NONE |

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____

Date: _____

Practice: _____

Today's Date: _____

Name: _____ DOB: _____ Chart Number: _____

Sex: M F Marital Status: Single Married Widowed Divorced SS#: _____

E-mail: _____ Spouse/Partner Name: _____

E-mail newsletters, reminders, statements, etc.

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Other #: _____

Employer: _____ Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance: _____ Are you the insured? Yes No

Insured Information

Subscriber Name: _____ Relationship to insured: Spouse Child Self other

Phone #: _____ Sex: Male Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

Secondary Insurance: _____ Are you the insured? Yes No

Insured Information

Subscriber Name: _____ Relationship to insured: Spouse Child Self Other

Phone #: _____ Sex: Male Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

How did you find out about our practice? Physician Internet Telephone book Family member Friend
 Other: _____

What is the reason for your visit today? _____

How long has this bothered you? 1 2 3 4 5 6 7 days weeks months years

What treatments have you tried & have they been effective? _____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10

The pain quality is: burning constant dull sharp shooting throbbing tingling Other: _____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

Andrea Hyperbaric Wound Care and Podiatry Center

Practice: _____

Today's Date: _____

Name: _____	Chart #: _____	Date of birth: _____
Race: _____ <small>(White, American Indian, Asian, Black or African, Native Hawaiian, Hispanic, etc.)</small>	<input type="checkbox"/> I prefer not to answer	<input type="checkbox"/> I do not know
Ethnicity: _____	<input type="checkbox"/> I prefer not to answer	<input type="checkbox"/> I do not know
Preferred Language: _____	<input type="checkbox"/> I prefer not to answer	
Pharmacy Name: _____	Pharmacy Phone: _____	
Pharmacy Address: _____	City, State, Zip: _____	
Primary Care Physician: _____	Phone: _____	Date Last Seen: _____
Address: _____		
Referring Physician: _____	Phone: _____	Date Last Seen: _____
Address: _____		

Privacy Information Preferences

Do you want to be exempt from public reporting? Yes No Can we send mail to the address on file? Yes No

Can we call the phone number on file? Yes No Can we leave voicemail on machine? Yes No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? Yes No

If yes, please provide your e-mail address: _____

Who can we leave messages with? Wife Husband Daughter Son Other: _____

Name(s): _____

Smoking Status

Current Every Day Smoker Never Smoker

Current Some Day Smoker I decline to answer

Former Smoker

Emergency Contact:

NAME: _____

Phone Number: _____

Current Medications

No Known Medications I take the following medications:

Use the back of this form if more room is needed

Allergies

No Known Allergies No Known Drug Allergies

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits):* I authorize payment of medical benefits to the practice named above. *(Release of Information):* I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy):* I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History):* I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____

**ANDREA HYPERBARIC
WOUND CARE & PODIATRY CENTER**

HYPERBARIC PRE-TREATMENT CHECKLIST

PRE-TREATMENT CHECKLIST

Replace Clothing with 100% cotton gown
Remove jewelry (wedding rings may be covered)
Remove hearing aids
Remove contact lenses (glasses permitted)
Remove prosthesis
No hair spray, hair oils, make-up
No food, candy, battery operated toys, radios, etc. or reading material
Explain pressure & temperature changes, equalization techniques, valsalva
Possibility of increased pain @ wound side
Intercom, TV, Radio
Ground Wire
No petroleum based or Sulfamylon dressings during treatment
Vitals on all patients, pre & post treatment
Note all meds taken during the day
Meal or snack within 60 minutes prior to treatment
Signature on consent form
Give patient HBO Information Sheet
Blood Glucose on all diabetic patients - pre & post treatment
Number of treatments, appointment time
Possible side effects:
1. Barotrauma
2. Cerebral Air Embolism, Pneumothorax O2 Toxicity, worsening myopia
maturing of cataracts

Signature of Facilitator

Date

Print Name

The Hyperbaric procedures have been explained to me and my questions have been answered satisfactorily

Patient Signature

Date

Assignment of Benefits Form

Practice Name _____
Address _____
City, State, Zip _____
Phone _____

Date _____

Patient: _____

Employer: _____

Claim Group: _____

SS# / ID#: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

Practice Name
Practice Address

or

If my current policy prohibits direct payment to Doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Patient Name
C/o Practice Name
Practice Address

for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at _____ this _____ day of _____, 20____
(Time) (Month) (Day) (Year)

Signature of Policyholder

Witness

ANDREA HYPERBARIC WOUND CARE AND PODIATRY CENTER

Informed Consent for Hyperbaric Medicine

I, _____, hereby consent to and authorize hyperbaric oxygen therapy (HBO) and wound care to be performed on me as ordered by my physician.

I know and realize that hyperbaric medicine involves more than one treatment and I hereby authorize the performance of the number of treatments which in my physician's opinion are necessary to treat my condition.

The nature and purpose of hyperbaric medicine has been explained to me by Doctor(s) _____ and I hereby acknowledge that I know and understand the nature and purpose of these treatments. Additionally, these physicians have explained to me the benefits, consequence, risks (listed below), side effects, including potential problems that might occur during recuperation, and alternatives to hyperbaric medicine including relative risks, benefits, and side effects related to alternatives, including no treatment and have given me the opportunity to ask questions and have answered my questions concerning this matter.

Risks of Hyperbaric Oxygen Therapy:

1. Oxygen Toxicity-lung; central nervous system (seizure)
2. Barotraumas – eardrum discomfort/rupture; sinus pain
3. Myopia, reversible after HBO (nearsightedness / change in vision)
4. Increased cataract growth rate (thicken of lenses / changes in vision)
5. Lung over pressure – embolism; pneumothorax (collapsed lung/bubbles in bloodstream)
6. Safety issues

The undersigned recognizes that all persons furnishing hyperbaric services, including the physicians, are independent contractors and are not employees or agents of the associated medical facility.

I hereby consent to the performance of hyperbaric medicine.

Patient/Authorized Signature

Date

Relationship to patient

Witness

Patient name

Date

I hereby certify that I have explained the nature, purpose, benefits, likelihood of success, side effects, including potential problems that might occur during recuperation alternatives to hyperbaric medicine including relevant risks, benefits and side effects related to alternatives, including no treatment.

Physician: _____

(Print name)

(Signature)

Date

**ANDREA HYPERBARIC, WOUND CARE AND
PODIATRY CENTER**

**RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS & GUARANTEE
OF PAYMENT STATEMENTS**

Account #

AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE AND DIRECT THE ABOVE NAMED MEDICAL FACILITY AND PHYSICIANS HAVING TREATED ME, TO RELEASE TO GOVERNMENTAL AGENCIES, INSURANCE CARRIERS, OR OTHERS WHO ARE FINANCIALLY LIABLE FOR MY MEDICAL CARE, ALL INFORMATION REGARDING MY TREATMENT.

THIS INCLUDES ALL MEDICAL RECORDS, AND TEST RESULTS NEEDED TO SUBSTANTIATE PAYMENT FOR SUCH MEDICAL CARE AND TO PERMIT REPRESENTATIVES THEREOF TO EXAMINE AND MAKE COPIES OF ALL RECORDS RELATING TO SUCH CARE AND TREATMENT.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

ASSIGNMENT TO ANDREA HYPERBARIC, WOUND CARE ANDPODIATRY CENTER: I HEREBY ASSIGN TRANSFER AND SET OVER TO THE ABOVE NAMED MEDICAL FACILITY SUFFICIENT MONIES AND OR BENEFITS TO WHICH I MAY BE ENTITLED FROM GOVERNMENTAL AGENCIES, INSURANCE CARRIERS, OR OTHERS WHO ARE FINANCIALLY LIABLE FOR MY MEDICAL CARE TO COVER THE COSTS OR CARE AND TREATMENT RENDERED TO ME OR MY DEPENDENTS IN THIS OFFICE.

FINANCIAL AGREEMENT: THE UNDERSIGNED AGREES, WHETHER HE/SHE SIGNS AS AGENT OR AS PATIENT THAT IN CONSIDERATION FOR THE SERVICES RENDERED OR TO BE RENDERED. TO PAY ALL CHARGES INCURRED DURING THE HOSPITALIZATION OF SAID PATIENT. AND AGREE TO PAY ALL CHARGES WHICH ARE NOT COVERED BY MEDICAL INSURANCE.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

**WITNESS FOR ANDREA HYPERBARIC, WOUND CARE ANDPODIATRY
CENTER**

**ANDREA HYPERBARIC
WOUND CARE AND PODIATRY CENTER**

CONSENT FOR PHOTOGRAPHS

Patient _____ Place _____ Date _____

In connection with the medical services, which I am receiving from my physician, Dr. _____, I consent that photographs may be taken of me or parts of my body, under the following conditions:

1. The photographs may be taken only with the consent of my physician and under such conditions and at such times as may be approved by him.
2. The photographs shall be taken by my physician or by a photographer approved by my physician.
3. The photographs shall be used for medical records and if in the judgement of my physician, medical research, education or science will be benefited by their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which he may deem proper in the interest of medical education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name.
4. The aforementioned photographs may be modified or retouched in any way that my physician, in his discretion, may consider desirable.

Signed _____
(Patient) Date _____

Witness _____
Date _____