WOUND CARE INSTITUTE OF OCEAN COUNTY

Name:_____ SS#: _____

Date of Birth: _____ Age: _____ Home Phone #: _____

Cell#: _____ Email: _____

Address:_____

City: _____ State: _____ Zip: _____

PLEASE CIRCLE: Female / Male Married / Single / Other

Race: White / American Indian / Asian / African American / Other:_____

Ethnicity: Hispanic or Latino / Not Hispanic or Latino

Primary Language: _____

Employed By: _____ Occupation:_____

Business Phone:_____Address:_____

City: _____ State:_____ Zip:_____

PHARMACY: _____ Phone: _____

Primary Care Physician:_____ Phone: _____

Please list any specialists currently treating you:

Specialist: _____ Specialty: _____

Specialist: _____ Specialty: _____

In Case of an Emergency, whom may we contact? _____

Relationship: _____Phone Number: _____

Whom May We Thank for Referring You? _____

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 SO CHOSE) AND UNDERSTOOD THE NOTICE. TO ASSIST IN THE COORDINATION OF MY CARE, I HEREBY GIVE WRITTEN CONSENT OT THE DOCTORS OF WOUND CARE INSTITUTE OF OCEAN COUNTY TO VIEW MY PRESCRIPTION HISTORY PROVIDED THROUGH ELECTRONIC HEALTH RECORD EXCHANGE.

_____ _____

SIGNATURE DATE

WOUND CARE INSTITUTE OF OCEAN COUNTY

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient Name: _____

Date of Birth: _____

I request that all communications to me (by telephone, mail or otherwise) by Wound Care Institute of Ocean County and/or its staff be handled in the following manner:

- For Written communications: Address to:

  _____

  _____

  _____

- For Oral communications: Call Telephone #: _____

  We may discuss your medical history with (Name & Relationship to You):

  _____

  We may discuss your bill with (Name & Relationship to You):

  _____

Patient Signature: _____

Date: _____

For Practice Use Only

Practice: Accepts Denies

Entered (Initial): _____

Date: _____