

New patient forms

1 of 3 - About you

Answer what you can; leave anything uncertain for the visit. We can help with these forms or an interpreter. Bring your insurance cards and medicine list. Save a copy if typing, then print and sign. Bring completed forms to your visit; do not email them.

Full legal name

Date of birth

Name you use (if different)

Best phone

Mailing address - street city state and ZIP

Visit address or facility and room (only if different)

Email (optional)

Preferred language or help needed

Who can we contact in an emergency?

Name and relationship

Phone

An emergency contact is not automatically a medical decision-maker or authorized to receive routine updates.

Insurance - bringing your cards is easiest

Coverage ☐ Cards attached / will bring ☐ Uninsured ☐ Self-pay by choice

If no card: insurance plan and member ID

Subscriber name and birth date (only if not you)

Bring all insurance cards. Tell us if this visit involves a work injury, car accident, or another claim.

Your care team

Primary care clinician

Pharmacy name and location

Home nurse facility or person helping with dressings and their phone (if any)

405 Kenmore Rd, Havertown, PA | (215) 760-9443 | contact@primehealcare.com

Your health and wound

2 of 3 - A short history; we will discuss the details together

Patient name

Date of birth

Medicine list ☐ Attached / will bring ☐ Listed below ☐ None ☐ Not sure

Medicine names and doses - include blood thinners steroids and antibiotics

Allergies ☐ None known ☐ Listed below ☐ Not sure

Medicine tape latex or dressing allergy AND what reaction you had

Check any you have☐ Diabetes ☐ Poor circulation ☐ Leg swelling / vein problems ☐ Heart or kidney disease
☐ Lowered immunity ☐ Past MRSA / bone infection ☐ None known ☐ Not sure

Other important conditions or operations (or attach a list)

Your wound - describe the main area or areas

Where is the wound? Include right or left

When did it start?

How did it start? For example: surgery injury pressure or not sure

What have you noticed?☐ Improving ☐ Worsening ☐ Drainage / odor ☐ Redness / swelling ☐ Fever / chills
☐ Not sure

Current dressing or treatment and how often it is changed

Pain from 0 to 10 (0 = none; 10 = worst)

Main question or concern

Help needed ☐ Dressings / supplies ☐ Moving / pressure relief ☐ Food / transport ☐ None

Please tell us promptly about fever, spreading redness, or worsening pain. For a medical emergency or uncontrolled bleeding, call 911. Do not wait for this form to be reviewed.

Consent and your choices

3 of 3 - Please read, choose, and sign

Patient name

Date of birth

Routine care and billing

I agree to evaluation and routine wound care. The team will explain the plan and answer questions. I may decline or stop care; healing is not guaranteed. This does not consent to debridement, biopsy, grafts, surgery, anesthesia, or other procedures needing a separate informed-consent discussion.

Prime Heal may bill my insurance and receive direct payment when permitted. I owe only lawful amounts under my coverage. I may ask about costs and self-pay estimates. This does not authorize automatic charges or waive coverage, appeal, surprise-billing, Medicare, or Medicaid protections.

Signature for routine care and billing

Date and time

Printed name and legal authority (if signing for the patient)

Contact preferences - optional; choose what works for you

Voicemail ☐ Callback number only ☐ Appointment details okay ☐ No voicemail

Optional scheduling messages ☐ Text okay ☐ Email okay ☐ Neither

Texts and ordinary email may not be secure. Scheduling only: no clinical details, emergencies, or marketing. You may change these choices. Write any private contact instructions below.

Private contact instructions OR person allowed care updates and limits (optional)

Clinical wound photos - optional; select one

My choice ☐ Agree ☐ Decline ☐ Discuss first

If I agree, photos are for my clinical record and care only, not marketing or public use. I can stop future photos; existing photos stay in the record as required. Declining does not by itself prevent care.

Signature for the optional choices above

Date and time

Privacy notice receipt - separate from consent to care

I received the Notice of Privacy Practices effective October 11, 2026. Signing only confirms receipt, not permission to disclose records. I can receive care even if I do not sign this receipt.

Signature acknowledging receipt of the privacy notice

Date and time