WILMINGTON HEALTH

Patient Information

Account No. _____

Doctor's No. _____

PLEASE ANSWER ALL QUESTIONS

PATIENT INFORMATION

NAME: LAST _____ FIRST _____ MIDDLE _____

BIRTHDATE _____ SS# _____

HOME PHONE _____

CELL PHONE _____

EMAIL ADDRESS _____

SEX ☐M ☐F

RACE ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Other Race ☐ American Indian/Alaskan

ETHNIC ORIGIN ☐ Hispanic ☐ Non-Hispanic

Language _____

ADDRESS _____ ADDRESS 2 _____

CITY _____ STATE _____

ZIP CODE _____ 4 DIGIT _____ COUNTY _____

COUNTRY _____ MARITAL STATUS _____

EMPLOYER _____ ADDRESS _____

WORK PHONE _____ EXT _____ PRIMARY CARE DOCTOR _____

INSURANCE INFORMATION

1) INSURANCE CO _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

MEDICARE/ID# _____

GROUP # _____

2) INSURANCE CO _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

MEDICARE/ID# _____

GROUP # _____

POLICY HOLDER INFO

NAME _____

RELATIONSHIP TO PATIENT _____

SS# _____

ADDRESS _____

CITY/STATE/ZIP _____

DATE OF BIRTH _____

EMPLOYER _____

ADDRESS _____

CITY _____ ST _____ ZIP _____

POLICY HOLDER INFO

NAME _____

RELATIONSHIP TO PATIENT _____

SS# _____

ADDRESS _____

CITY/STATE/ZIP _____

DATE OF BIRTH _____

EMPLOYER _____

ADDRESS _____

CITY _____ ST _____ ZIP _____

(1) I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the cost of the interest, collection and legal action (if required). (2) We are required by applicable federal and state law to maintain the privacy of your medical information. Our Notice of Privacy Practices document informs you of our legal duties, and your rights concerning your medical information. We must follow the privacy practices described in our notice. You may request a copy of our notice at any time. (3) My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Wilmington Health. This assignment covers any and all benefits under medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will insure such payment to Wilmington Health.

Patient Signature _____ Date/Time _____

Responsible Party Signature _____ Date/Time _____

AUTHORIZATION for USE and/or DISCLOSURE of PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information as described in Section B below**.** I understand that this authorization is voluntary.

I understand that, if the persons or organizations I authorize below are not health care providers, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Section A: Patient Information (please print):

Name: _____

Address: _____

Account Number: _____ Social Security Number:_____

Date of Birth: _____ Telephone: _____

Section B: Protected Health Information to Be Used and/or Disclosed:

Do you wish for us to discuss all your protected health information with your family/friends or do you prefer that only specific information be released?

☐ All medical information, except psychotherapy information.

☐ Psychotherapy notes.

If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information.

☐ Specific information (please describe): _____

_____

Entities Authorized to Use or Disclose: Wilmington Health

Families, Friends and Other Authorized to receive and Use: (please name specifically any family/friends to which we may release your protected health information either in writing or verbally):

_____ _____

_____ _____

SECTION D: Purpose of Use or Disclosure of Protected Health Information.

☐ So family member, friend or caregiver may have knowledge of or assist in my medical care or payment for medical care. ☐ At the request of the individual

☐ Other _____

SECTION E: Expiration

This authorization will expire (complete one): ☐ 2 Years after my death

☐ Until I revoke permission in writing ☐ Future Date ____/____/_____

☐ On the occurrence of the following event:

_____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Wilmington Health Privacy Officer **Telephone:** (910) 796-7701
Fax: (910) 772-1307 **Address:** 1202 Medical Center Drive, Wilmington, NC 28401
E-mail: privacy @wilmingtonhealth.com

Inability to Condition Treatment: I understand that Wilmington Health may not condition my treatment on my refusal to sign this authorization.

If you would like for us to leave medical information regarding your care (i.e. lab results) or appointments on an answering machine please complete the section below.

Wilmington Health may leave a message regarding my medical information on the answering machine at this number (____) ____ - _____.

I acknowledge that I have been made aware of Wilmington Health's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of the Wilmington Health Notice of Privacy Practices.

SIGNATURE—YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

Include this authorization in the individual's medical record.

MEDICAL DATA SHEET

For Patients 18 years of age and older

NAME: _____ DATE: ___/___/___

AGE: _____ DOB: ___/___/___

1. What is the main reason you are seeking a physician's advice?

_____

_____

2. Please list all allergies:

Drug Allergies: _____ Other Allergies: _____

3. List health information for family members

Relationship	Age Attained	Deceased?	State of Health Known Disease of Cause of Death
Father			
Mother			
Brothers			
Sisters			
Children			
Spouse			

4. List family members who are seeing physicians of Wilmington Health:

5. Do you have any blood relatives who have any of the following:
(Please circle and indicate relationship)

TB
Emphysema
Asthma
Heart Disease
High Blood Pressure
Stroke
Diabetes
Sickle Cell Anemia

Kidney Disease
Blood Disorder
Bleeding Tendency
Epilepsy
Nervous Disorder
Suicide

Breast Cancer
Colon Cancer
Prostate Cancer
Ovarian Cancer
Uterine Cancer

NAME: _____
DATE: _____

6. Past Medical History

   Previous hospitalizations (In chronological order)

   a. Date: _____ Hospital: _____
      Reason for admission:_____
      Surgical procedures? _____
   b. Date: _____ Hospital: _____
      Reason for admission:_____
      Surgical procedures? _____
   c. Date: _____ Hospital: _____
      Reason for admission:_____
      Surgical procedures? _____

7. Have you had any of the following conditions? (please circle those that apply)

Heart Disease	Ulcers	Blood Clots	Other Medical Problems (List)
High Blood Pressure	Gallstones	Seizures	
Stroke	Pancreatitis	Nervous Illness	
Asthma	Kidney Disease	Alcoholism	
Emphysema	Diabetes	Cancer	
Tuberculosis	Bleeding Tendency	Blood Disorders	

8. Habits:

   Amount of alcohol consumed per week: _____
   Number of cigarettes smoked per day: _____
   Number of years Smoking: _____

9. Please list travels off the North American Continent or Europe:
   Date: _____ Place: _____

10. Please list all medications you are presently taking: (Doses and directions). Please include over the counter medications (such as pain relievers, vitamins, supplements and herbals).

    _____
    _____

11. Have the following tests been performed elsewhere? Indicate date)

Colonoscopy	_____
PSA	_____
Pap Smear	_____
Mammogram	_____
Bone Density	_____
Tuberculin Test	_____
Chest X-Ray	_____
EKG	_____

12. Name of pharmacy you use to fill your prescriptions:_____

AUTHORIZATION for USE, DISCLOSURE and/or
REQUEST of PROTECTED HEALTH INFORMATION
1920 South 16th Street
Wilmington, NC 28401
Phone: 910-341-3308
Fax Release Form to: 910-341-3419
Fax Records to: 910-341-1900

SECTION A: Psychotherapy Notes. ☐ Check if this authorization is for psychotherapy notes. **If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information. Identify the psychotherapy notes by checking "Other" in Section C and describing in the space provided, do not check any other boxes or types of information.**

SECTION B: The Individual (or the Individual's Personal Representative) confirming the authorization. I authorize the use and/or disclosure of my protected health information as described in Section C below**.** I understand that this authorization is voluntary.

I understand that, if the persons or organizations I authorize below are not health care providers, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Patient's Name: _____

Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Telephone: _____ **E-mail**: _____

Date of Birth: _____ **Social Security # (last 4 digits only)**: _____

SECTION C: The use, disclosure and/or request being authorized (minimum necessary).

☐ Present year only ☐ 1 year ☐ 2years **History/Office Notes**
☐ Present year only ☐ 1 year ☐ 2years **Labs**
☐ Last **Eye Exam** ☐ Last **Foot Exam**
☐ 2 years **Pap Smears** ☐ 2 yrs **Mammograms** ☐ All **Immunization** summaries
☐ All **Colonoscopy** and **EGD** procedure reports ☐ All **Pathology** reports
☐ All **Radiologic studies (Bone Density, CT/CTA, MRI/MRA**, **US**, **Vascular**, etc)
☐ All **Cardiac Studies**
☐ All **Hospital Admissions, H&Ps**, **Consults, Operative reports**, **Discharges**
☐ **Other (Please be specific and DO NOT request ALL Records)**

_____

Entities Authorized to **Use or Disclose**:
Records requested **FROM:**
Name of provider/organization:

_____

Address _____

_____

Phone #: _____

Fax #: _____

Entities Authorized to **Receive and Use**:
Records to be **SENT TO**:
Name of provider/organization/person:

_____

Address_____

_____

Phone #: _____

Fax #: _____

SECTION D: Preference for Receipt of Records

☐ Regular Mail ☐ Fax:# _____ (Maximum 50 pgs)
☐ Pick up by: _____(2-3 day processing minimum) Where: _____
☐ Retrieve from Website (Personal copies only)
☐ Electronic Copy (disk)

SECTION E: Purpose of Use, Disclosure and/or Request of Protected Health Information

☐ Personal Use ***You will be charged a state regulated fee for a personal copy of your records ($10 minimum/$50 maximum).**
☐ Changing Provider/Continuity of Care ☐ Insurance ☐ Attorney
☐ Other _____

SECTION F: Expiration

This authorization will expire (**complete one**): ☐ 2 Years after my death
☐ Until I revoke permission in writing ☐ Future Date ____/____/_____
☐ On the occurrence of the following event:
_____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Wilmington Health Privacy Officer **Telephone:** (910) 796-7701
Fax: (910) 341-3419 **Address:** 1920 South 16th Street, Wilmington, NC 28401
E-mail: privacy@wilmingtonhealth.com

Inability to Condition Treatment: I understand that Wilmington Health may not condition my treatment on my refusal to sign this authorization.

SECTION F: SIGNATURE

SIGNATURE—YOU MAY REFUSE TO SIGN THIS AUTHORIZATION AND THE REQUEST WILL BE CONSIDERED NULL & VOID.

PERSONAL COPIES WILL INCUR A FEE. REFER TO "SECTION E" FOR INFORMATION.

Signature: _____ **Date**: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

WITNESS: _____ **Date**: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.
Include this authorization in the individual's medical record.