Account No.______________________
Doctor's No. _____________________

PLEASE ANSWER ALL QUESTIONS

NAME: LAST:____________________ FIRST ____________________ MIDDLE ______________

BIRTHDATE ______________ SS# ______________

SEX

☐ M ☐ F

HOME PHONE ______________________________

CELL PHONE ______________________________

EMAIL ______________________________

RACE

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

ETHNIC ORIGIN

☐ Hispanic
☐ Non-Hispanic

ADDRESS ______________________________ ADDRESS 2______________________________

CITY ______________________________ STATE______________________________

ZIP CODE ______________ 4 DIGIT__________ COUNTY______________________________

COUNTRY______________________________ MARITAL STATUS ______________________________

EMPLOYER ______________________________ ADDRESS ______________________________

WORK PHONE ______________ EXT__________ PRIMARY CARE DOCTOR ______________________________

RESPONSIBLE PARTY (Patients 18 years of age or younger)

NAME ______________ BIRTHDATE ________ HOME PHONE ______________ CELL PHONE ______________

ADDRESS ______________ CITY ____________ STATE __________ ZIP__________ SS#______________

EMPLOYER______________RELATIONSHIP________ MARITAL STATUS ______________ SEX______________

ADDRESS______________ CITY ____________ STATE __________ ZIP __________ PHONE ______________

MOTHER (Patients 18 years of age or younger)

NAME ______________ BIRTHDATE ________ HOME PHONE ______________ CELL PHONE ______________

ADDRESS ______________ CITY ____________ STATE __________ ZIP__________ SS#______________

EMPLOYER______________________________ MARITAL STATUS ______________ SEX______________

ADDRESS______________ CITY ____________ STATE __________ ZIP __________ PHONE ______________

FATHER (Patients 18 years of age or younger)

NAME ______________ BIRTHDATE ________ HOME PHONE ______________ CELL PHONE ______________

ADDRESS ______________ CITY ____________ STATE __________ ZIP__________ SS#______________

EMPLOYER______________________________ MARITAL STATUS ______________ SEX______________

ADDRESS______________ CITY ____________ STATE __________ ZIP __________ PHONE ______________

INSURANCE INFORMATION

1) INSURANCE CO______________________________ 2) INSURANCE CO______________________________

ADDRESS ______________ ______________ ADDRESS ______________________________

CITY ______________STATE________ ZIP__________ CITY ______________ STATE__________ ZIP______________

MEDICARE/ID#______________________________ MEDICARE/ID#______________________________

GROUP # ______________________________ GROUP # ______________________________

POLICY HOLDER INFO **POLICY HOLDER INFO**

NAME______________________________ NAME______________________________

RELATIONSHIP TO PATIENT ______________________________ RELATIONSHIP TO PATIENT ______________________________

SS#______________________________ SS#______________________________

DATE OF BIRTH ______________________________ DATE OF BIRTH ______________________________

EMPLOYER ______________________________ EMPLOYER ______________________________

ADDRESS ______________________________ ADDRESS ______________________________

CITY ______________ ST __________ ZIP __________ 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) I authorize my insurance carrier to release information regarding my coverage to Wilmington Health. I also authorize agents of any hospital, treatment center or previous physicians to furnish copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within Wilmington Health. (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 ______________________________

A copy of this authorization and assignment shall be considered as valid as the original.

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.

Patient Information Questionnaire

Name:____ Phone #:________________ Today's Date:_______________

DOB:________________________ Age:_____________ Referred by:_______________________________________

Please Provide The Following Information

General Information

What is your primary reason for coming to see us today? Routine Exam Other __________________________

How many times have you been pregnant? _______________

Gynecologic and Obstetric Review:

If you have menstrual periods, when did your last menstrual period start? ________________________

If you do not have periods, please answer the following

Have you had a hysterectomy? Y N Have you been through menopause? Y N

Have you had your ovaries removed? Y N Do you take hormone medication? Y N

Are you presently sexually active? Y N Have you ever been sexually active? Y N

Do you plan a pregnancy in the near future? Y N

What are you using to prevent pregnancy? Nothing Condoms Diaphram Pills Shots Implants IUD Tubal Ligation Vasectomy Other ______________________________

Do you want to continue your present method? Y N

OB/GYN Review of Systems:

Have you ever had gonorrhea, Chlamydia, herpes, genital warts or other sexually transmitted disease? Y N

Do you want to be tested for sexually transmitted diseases today? Y N

Have you ever experienced problems with your breasts or pelvic organs? Y N

Have you had any GYN or abdominal surgery? Y N

Do you have:

Breast Problems Breast Pain Breast Lumps Nipple Discharge Abdominal Pain Pelvic Pain Genital Pain

Heavy Periods Painful Periods Irregular Periods Leakage of Urine Abnormal Vaginal Discharge Sexual Problems

Infertility Abnormal Body Hair Other Problems ____

General Medical Review of Systems:

Did you have any serious illness as a child? Y N

Have you had problems with:

Fevers Night Sweats Eyes/Vision Ears/Nose/Throat Heart Chest Pain Blood Pressure

Lungs Breathing Stomach Ulcers Liver Gallbladder Bowels

Kidneys Bladder Back/Spine Blood Bruising Diabetes Thyroid

Headaches/Migraines Seizures/Convulsions Stroke Blood Clots in Veins or Lungs

Varicose Veins Skin Muscle Disorders Cancer Mental Illness

Social and Family History:

What is your marital status? S M D W Where do you work?______________________________________

What is your job? ______________________________________

Do you smoke or use tobacco? Y N If "yes" how many per day?______________________________

Do you drink alcohol? Y N If "yes" how many drinks per day?_________________________

Have you ever used street drugs? Y N If "yes" when was the last time?__________________________

Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by anyone? Y N

Within the last year, has anyone forced you to have any sexual activities? Y N

Since your Last Visit, has anyone in your family developed: Colon Cancer Breast Cancer Ovarian Cancer Diabetes Heart Disease Tuberculosis Birth Defects Bleeding Disorders Mental Illness

Are you up to date on your immunizations? Y N