WILMINGTON HEALTH
wilmingtonhealth.com

Demographics

Please print, complete all fields, and sign.

Office Use Only: Recorded By: _____ Date: _____

Patient Last Name_____ Suffix_____ First_____ Middle_____

Prior Last Name_____Nickname_____SSN_____Birthdate_____ Male____ Female_____

Billing or PO Box Address

Street_____ Apt/Bldg/Lot_____

City_____ State_____ Zip_____

County_____ Country: US_____ Other_____

Secondary or Physical Address

Street_____ Apt/Bldg/Lot_____

City_____ State_____ Zip_____

County_____ Country: US: _____Other_____

Primary Care Provider_____ Marital Status_____ Race_____ Language_____ Ethnicity_____

1-Primary Insurance Name _____

Policy ID#_____ Group#_____

Insurance Address_____

City_____ State_____ Zip_____

Policy Holder (Sponsor) Name_____

Birthdate_____ Sex_____ Phone_____

Street _____ Apt/Bldg/Lot_____

City_____ State_____ Zip_____

Policy Holder's Relationship to Patient_____

Employer_____

2-Secondary Insurance Name _____

Policy ID#_____ Group#_____

Insurance Address_____

City_____ State_____ Zip_____

Policy Holder (Sponsor) Name_____

Birthdate_____ Sex_____ Phone_____

Street _____ Apt/Bldg/Lot_____

City_____ State_____ Zip_____

Policy Holder's Relationship to Patient_____

Employer_____

Patient Contact Information

Home Phone_____ Cell_____

Day Phone_____ Alternate_____

Preferred Contact (check 1) Home____ Cell____ Work____ Portal____

Preferred Notification (check 1) Phone___ Text___ Voice Reminders____

E-Mail_____ Decline E-Mail____

Patient Portal (check 1) Desires registration____ Already registered____

Mother's Information (of patient under 18)

First Name_____ Middle_____

Last_____ SSN_____

Phone_____ Birthdate_____

Street _____ Apt/Bldg/Lot_____

City_____ State_____ Zip_____

E-Mail_____ Decline E-Mail____

Father's Information (of patient under 18)

First Name_____ Middle_____

Last_____ Suffix____ SSN_____

Phone_____ Birthdate_____

Street _____ Apt/Bldg/Lot_____

City_____ State_____ Zip_____

E-Mail_____ Decline E-Mail____

Emergency Contact Information

First Name_____ Middle _____Last_____ Relationship_____

Street _____City_____State_____Zip_____

Birthdate _____Home Phone _____Cell _____Work_____

(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 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.

	Print Name	**Sign Name** (Signature Required)	**Relationship to Patient**	**Date**
Patient				
Responsible Party (Of Patient Under 18 Or HealthCare POA)				

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

1202 Medical Center Dr.
Attn: Medical Records
Wilmington, NC 28401
Phone: 910-341-3308
Fax Requests to: 910-341-3419
Fax Records to: 910-341-1900

Authorization for Use, Disclosure, and/or Request of Protected Health Information

Patient Name: _____

Date of Birth_____ Last four digits of Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Specific information being requested:

- ☐ History/Office notes
- ☐ Laboratory test results
- ☐ Pap Smears
- ☐ Mammograms
- ☐ Immunizations
- ☐ Colonoscopy and/or EGD reports including associated pathology reports
- ☐ Radiology reports (includes Bone Density, CT/CTA, MRI/MRA, Vascular, etc.)
- ☐ Cardiology studies
- ☐ Other: (Please be specific as we will only be able to provide the information you list)

_____

Time Frame of records to be released: (examples: 1 year, 2016 – current, most recent, or last 3 visits)

_____

Unless initialed the following information will NOT be released or disclosed:

_____ HIV/AIDS/Communicable Disease Status

_____ Alcohol and/or Drug Abuse or Treatment

_____ Mental Health Status or Treatment

Entities Authorized to Use, Disclose, or Receive: If persons or organizations authorized 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.

Records Requested FROM:	**Records Being Sent TO:**
Name of Provider or Organization:	Name of Provider or Organization:
_____	_____
Address: _____	Address: _____
_____	_____
Phone: _____	Phone: _____
Fax: _____	Fax: _____

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Preference for receipt of records:

- ☐ Regular Mail
- ☐ Fax: _____ (maximum 50 pages)
- ☐ Electronic Copy (disk) (State regulated Hi-Tech fee of $6.50 applies)
- ☐ Pick up by: _____ at location _____

The purpose of the Use, Disclosure, and/or Request: (State regulated fees apply)

- ☐ Changing Provider/Continuation of Care
- ☐ Insurance
- ☐ Attorney
- ☐ Personal Use ($10 minimum, $50 maximum for paper copies)
- ☐ Other: _____

This Authorization will expire: (choose one)

- ☐ 2 years after death of patient
- ☐ Upon written revocation
- ☐ Future Date: _____
- ☐ On the occurrence of the following event: _____

By signing below, I understand:

- I authorize the use and/or disclosure of my protected health information as described in this document.
- I may revoke this authorization at any time by providing written notice of my revocation. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before notice of revocation of authorization was received.
- I may refuse to sign this authorization and the request will be considered null and void.
- Wilmington Health may not condition my treatment on my refusal 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: _____

If you have concerns about your privacy rights, please contact Wilmington Health Privacy Officer:
Phone: 910-796-7701 Fax: 910-772-1307 Address: 1202 Medical Center Dr. Wilmington, NC 28401
Email: privacyofficer@wilmingtonhealth.com

PERSONAL HISTORY

Name: Date:

Address: Chart No.:

P.O. Box Zip:

Doctor:

Family or Referring Physician:

Current Medical Problem:

Illnesses:

Diabetes	Liver Disease	Kidney Disease	Stroke	Seizures
Asthma	Hypertension	Alcoholism	TB	Cancer
Heart Disease	Lung Disease	Ulcers	Gallstones	Other
Jaundice				

Previous Surgery:

Date Surgery Doctor

Previous Medical Problems (if any):

Allergies: Medicines:

Other:

Social History:

Marital status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Use of alcohol: Never _____ Rarely _____ Moderate _____ Daily _____

Use of tobacco: Never _____ Previously, but quit _____ Current packs/day _____

Use of drugs: Never _____ Type/Frequency _____

Excessive exposure at home or work to: Fumes _____ Dust _____ Solvents _____ Air-borne particles _____ Noise _____

FAMILY HISTORY	Sex	If Living		If Deceased	
		Age	Health	Age at Death	Cause
Father					
Mother					
Brothers/Sisters* *(Circle Sex)*					
	M F				
	M F				
	M F				
	M F				
	M F				
Husband/Wife					
Sons/Daughters* *(Circle Sex)*					
	M F				
	M F				
	M F				
	M F				
	M F				

*Since some names may be used for either men or women, please circle sex for each Brother, Sister, Son or Daughter.

Do you know of any blood relatives who have or have had: (Circle and give relationships)

Stroke	_____	Epilepsy	_____	Heart Attack	_____	Nervous Breakdown	_____
Cancer	_____	Suicide	_____	Stomach Ulcers	_____	Rheumatic Fever	_____
High Blood Pressure	_____	Migraine	_____	Kidney Disease	_____	Insanity	_____
Tuberculosis	_____	Asthma	_____	Goiter	_____	Congenital Heart	_____
Diabetes	_____	Hay Fever	_____	Arthritis	_____		
Leukemia	_____	Bleeding Tendency	_____	Colitis	_____		

Form #460

PLEASE REVIEW THE FOLLOWING LIST OF MEDICAL PROBLEMS AND CIRCLE THE APPROPRIATE ANSWER. THANK YOU.

System Review:

***CONSTITUTIONAL SYMPTOMS**

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

*** EYES**

Eye disease or injury	No	Yes
Wear glasses/contact lens	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes

*** EARS/NOSE/MOUTH/THROAT**

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problem or rhinitis	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

*** CARDIOVASCULAR**

Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Shortness of breath with walking or lying flat	No	Yes
Swelling of feet, ankles or hands	No	Yes

*** RESPIRATORY**

Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

*** GASTROINTESTINAL**

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements or constipation	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain or heartburn	No	Yes
Peptic ulcer (stomach or duodenal)	No	Yes

*** GENITOURINARY**

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change in force of strain when urinating	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Male - testicle pain	No	Yes
Female - pain with periods	No	Yes
Female - irregular periods	No	Yes
Female - vaginal discharge	No	Yes

Female -# pregnancies ____ # miscarriages ____

Female - date of last pap smear _____

*** MUSCULOSKELETAL**

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

*** INTEGUMENTARY (skin, breast)**

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

*** NEUROLOGICAL**

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes
Head injury	No	Yes

*** PSYCHIATRIC**

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

*** ENDOCRINE**

Glandular or hormone problem	No	Yes
Thyroid disease	No	Yes
Diabetes	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming drier	No	Yes
Change in hat or glove size	No	Yes

*** HEMATOLOGICAL/LYMPHATIC**

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

*** ALLERGIC/IMMUNOLOGIC**

History of skin reaction to:

Penicillin or other antibiotics	No	Yes
Morphine, Demerol, or other narcotics	No	Yes
Novocaine or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxin or other serums	No	Yes
Iodine, methiolate or other antiseptic	No	Yes

Other drugs/medications_____

Known food allergies_____