



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

Secondary or Physical Address

Street _____ Apt/Bldg/Lot _____

Street _____ Apt/Bldg/Lot _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

County _____ Country: US _____ Other _____

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 _____

Emergency Contact Information

First Name _____ Middle _____ Last _____ Relationship _____

Street _____ City _____ State _____ Zip _____

Birthdate _____ Home Phone _____ Cell _____ Work _____

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 _____

(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)				

Wilmington Health Primary Care Adult New Patient Health History Form

Name: _____ Date of Birth: _____ Email: _____

Local Pharmacy: _____ Mail order Pharmacy: _____

Reason for your visit today: _____

Previous/current physicians: _____

Personal Medical History - Please mark each of the following that applies to you (currently or in the past)

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergies
<input type="checkbox"/> Anemia
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Arthritis (Type _____)
<input type="checkbox"/> Asthma
<input type="checkbox"/> Atrial Fibrillation
<input type="checkbox"/> Enlarged Prostate (BPH)
<input type="checkbox"/> Blood Clots/Clotting Disorder
<input type="checkbox"/> Cancer (Type _____)
<input type="checkbox"/> COPD/Emphysema
<input type="checkbox"/> Coronary Artery Disease/Stents
<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes (Type 1 or 2) | <input type="checkbox"/> High Cholesterol
<input type="checkbox"/> GERD/Reflux
<input type="checkbox"/> Headaches/Migraines
<input type="checkbox"/> Heart Disease/Heart Failure
<input type="checkbox"/> Hepatitis/Liver Disease
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Irritable Bowel
<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Seizures
<input type="checkbox"/> Stroke
<input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Dementia
<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Lupus
Women Only:
<input type="checkbox"/> Abnormal PAP smear
_____ of Pregnancies
_____ of Children
Last Menstrual Period _____ |
|---|--|--|

Other Medical Problems (not listed above) _____

Medication List - Please list currently prescribed medications and any supplements.

Medication Name	Dosage	How often?	30/90 day RX?	Refills needed?

Allergies - Please describe any allergic reactions to medications, foods, or the environment.

Name: _____ Date of Birth: _____

Surgical History- If additional space is needed, please use back of sheet

Type of Surgery (example: hysterectomy)	Date (year)

Health Maintenance – Please bring a copy of your immunizations to your appointment.

	Date	Results
Colonoscopy		
Mammogram (women only)		
PAP smear (women only)		
DEXA (Bone density)		

Social History- What is your occupation? _____

Marital Status: Married Single Divorced Widowed Life Partner

Who do you live with? _____

Tobacco Use Current User Never User Former User
 Type Used: _____ Amount per day: _____
 # of Years used: _____ Quit Year _____

Alcohol Use Current User Never User Former User
 Type of alcohol: _____ How much per week: _____

Drug Use/Substance Abuse Current User Never User Former User

Family History- Please indicate your family history in the boxes below

Please check here if adopted (no family history available)

Family Member	Deceased?	List any medical problems (with age at diagnosis if known)
Mother		
Father		
Sister(s)		
Brother (s)		
Daughter(s)		Ages: _____
Son(s)		Ages: _____
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Other relations		



AUTHORIZATION for USE and/or DISCLOSURE of
PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information. 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 Information (please print):

Name: _____

Date of Birth: _____

Protected Health Information to Be Used and/or Disclosed:

Yes No May we discuss medical information regarding your care, test results, appointments or billing information with someone other than yourself? Please list any individuals you wish to have this permission.

	NAME	RELATIONSHIP
1		
2		
3		

Yes No May we leave a message regarding your medical care on your voicemail? If yes, please provide the phone number: _____

Yes No May we send you appointment reminders via Text Message? If yes please provide the phone number: _____
(Please note data charges may apply per your cell phone carrier)

Expiration: This authorization will remain in place until a notice of change is provided in writing

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: _____ 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: _____



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: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Specific information being requested:

- All Pediatric records
 - 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 as specific as we will only be able to provide the specific information you list)
-

Time Frame of records to be released: (examples: 1 year, 2016 – current, 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.

<p><u>Records Requested FROM:</u> Where are the records coming from? Name of Provider or Organization: _____ Address: _____ _____ Phone: _____ Fax: _____</p>
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<p><u>Records Being Sent TO:</u> Where are the records being sent? Name of Provider or Organization: _____ Address: _____ _____ Phone: _____ Fax: _____</p>
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Attn: Medical Records
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Phone: 910-341-3308
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Fax Records to: 910-341-1900

Preference for receipt of records:

- Regular Mail
- Fax: _____
- Electronic Copy (disk)

The purpose of the Use, Disclosure, and/or Request: Fees may apply based on form of and reason for release of information.

- Changing Provider/Continuation of Care
- Insurance
- Attorney
- Personal Use
- 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: _____ Last 4 digits of patient's social security number: _____

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

Personal Representative's Name: _____

Relationship to Patient: _____

Witness: _____ Date: _____

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