WILMINGTON HEALTH

Pediatric Patient Information (Patient less than 18 years old)

Account No. _____

Doctor's No. _____

PLEASE ANSWER ALL QUESTIONS

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 _____

RESPONSIBLE PARTY

NAME _____ BIRTHDATE _____ HOME PHONE _____ CELL PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ SS# _____

EMPLOYER _____ RELATIONSHIP _____ MARITAL STATUS _____ SEX _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____

MOTHER

NAME _____ BIRTHDATE _____ HOME PHONE _____ CELL PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ SS# _____

EMPLOYER _____ MARITAL STATUS _____ SEX _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____

FATHER

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 _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

MEDICARE/ID# _____

GROUP # _____

POLICY HOLDER INFO

NAME _____

RELATIONSHIP TO PATIENT _____

SS# _____

DATE OF BIRTH _____

EMPLOYER _____

ADDRESS _____

CITY _____ ST _____ ZIP _____

2) INSURANCE CO _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

MEDICARE/ID# _____

GROUP # _____

POLICY HOLDER INFO

NAME _____

RELATIONSHIP TO PATIENT _____

SS# _____

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. 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: _____

AUTHORIZATION TO CONSENT TO HEALTH CARE FOR MINOR

I, _____, of _____ County, State of _____, am the custodial parent having legal custody of _____, a minor child, age _____, born _____. I authorize _____ of _____ County, State of _____, to do any acts which may be necessary or proper to provide for the health care of the minor child, including but not limited to, the power (i) to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and (ii) to consent to and authorize any health care, including the administration of anesthesia, x-ray examination, performance of operations, or other procedures by physicians, dentists, and other medical personnel, except the withholding or withdrawal of life-sustaining procedures.

This consent shall be effective from the date it is executed until the date I terminate it in writing.

By signing here I indicate that (i) I have the understanding and capacity to recognize the importance of, to communicate, and assign the health care decision covered by this document, (ii) I am fully informed as to the contents of the document, and (iii) I understand the full scope and importance of this grant of powers to the agent named herein.

_____ _____

(Custodial Parent's Signature) (Date)

STATE OF _____

COUNTY OF _____

On this _____ day of _____, 20_____, personally appeared before me the named _____, to me known and known to me to be the person described in and who executed to foregoing instrument and that person acknowledges that he or she executed the same and being duly sworn to me, made oath that the statements in the foregoing instrument are true.

_____, Notary Public

My Commission Expires: _____ (OFFICIAL SEAL)

Medical Record # _____