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.

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: _____

Office Use Only: Recorded By _____ Date: _____

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**
(Witness Required if signed in Wilmington Health office)

_____ _____
WH Staff Signature as Witness **Date**
(of Custodial Parent's Signature if signed in Wilmington Health office)

Notary Public Required if signed outside of Wilmington Health office

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 *(OFFICIAL SEAL)*

My Commission Expires: _____