WILMINGTON HEALTH

Patient Information

Account No. _____

Doctor's No. _____

PLEASE ANSWER ALL QUESTIONS

PATIENT INFORMATION

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 _____

INSURANCE INFORMATION

1) INSURANCE CO _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

MEDICARE/ID# _____

GROUP # _____

2) INSURANCE CO _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

MEDICARE/ID# _____

GROUP # _____

POLICY HOLDER INFO

NAME _____

RELATIONSHIP TO PATIENT _____

SS# _____

ADDRESS _____

CITY/STATE/ZIP _____

DATE OF BIRTH _____

EMPLOYER _____

ADDRESS _____

CITY _____ ST _____ ZIP _____

POLICY HOLDER INFO

NAME _____

RELATIONSHIP TO PATIENT _____

SS# _____

ADDRESS _____

CITY/STATE/ZIP _____

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 _____

MEDICAL DATA SHEET

For Patients 18 years of age and older

NAME: _____ DATE: ___/___/___

AGE: _____ DOB: ___/___/___

1. What is the main reason you are seeking a physician's advice?

_____

_____

2. Please list all allergies:

Drug Allergies: _____ Other Allergies: _____

3. List health information for family members

Relationship	Age Attained	Deceased?	State of Health Known Disease of Cause of Death
Father			
Mother			
Brothers			
Sisters			
Children			
Spouse			

4. List family members who are seeing physicians of Wilmington Health:

5. Do you have any blood relatives who have any of the following:
(Please circle and indicate relationship)

TB
Emphysema
Asthma
Heart Disease
High Blood Pressure
Stroke
Diabetes
Sickle Cell Anemia

Kidney Disease
Blood Disorder
Bleeding Tendency
Epilepsy
Nervous Disorder
Suicide

Breast Cancer
Colon Cancer
Prostate Cancer
Ovarian Cancer
Uterine Cancer

NAME: _____
DATE: _____

6. Past Medical History

   Previous hospitalizations (In chronological order)

   a. Date: _____ Hospital: _____
      Reason for admission:_____
      Surgical procedures? _____
   b. Date: _____ Hospital: _____
      Reason for admission:_____
      Surgical procedures? _____
   c. Date: _____ Hospital: _____
      Reason for admission:_____
      Surgical procedures? _____

7. Have you had any of the following conditions? (please circle those that apply)

Heart Disease	Ulcers	Blood Clots	Other Medical Problems (List)
High Blood Pressure	Gallstones	Seizures	
Stroke	Pancreatitis	Nervous Illness	
Asthma	Kidney Disease	Alcoholism	
Emphysema	Diabetes	Cancer	
Tuberculosis	Bleeding Tendency	Blood Disorders	

8. Habits:

   Amount of alcohol consumed per week: _____
   Number of cigarettes smoked per day: _____
   Number of years Smoking: _____

9. Please list travels off the North American Continent or Europe:
   Date: _____ Place: _____

10. Please list all medications you are presently taking: (Doses and directions). Please include over the counter medications (such as pain relievers, vitamins, supplements and herbals).

    _____
    _____

11. Have the following tests been performed elsewhere? Indicate date)

Colonoscopy	_____
PSA	_____
Pap Smear	_____
Mammogram	_____
Bone Density	_____
Tuberculin Test	_____
Chest X-Ray	_____
EKG	_____

12. Name of pharmacy you use to fill your prescriptions:_____

Name_____

Date_____

REVIEW OF SYSTEMS

Do you suffer from or have difficulty with any of the below listed symptoms?
Check yes or no and circle specific problem if more than one are listed together.

Yes No

HEAD

- ☐ ☐ Trouble with eyesight
- ☐ ☐ Trouble with ears or hearing
- ☐ ☐ Nasal discharge
- ☐ ☐ Hay Fever, frequent sneezing
- ☐ ☐ Sinus trouble, post nasal drip
- ☐ ☐ Serious head injury

THROAT

- ☐ ☐ Hoarseness (persistent)
- ☐ ☐ Ulcer of tongue or mouth
- ☐ ☐ Trouble with gums or teeth
- ☐ ☐ Sore throat

GLANDULAR

- ☐ ☐ Enlargement of thyroid gland
- ☐ ☐ Nodes or kernels anywhere

LUNGS

- ☐ ☐ Asthma, wheezing
- ☐ ☐ Chronic cough
- ☐ ☐ Cough up blood
- ☐ ☐ Tuberculosis
- ☐ ☐ Shortness of breath
- ☐ ☐ Exposure to asbestos or other occupational hazard

CARDIOVASCULAR

- ☐ ☐ High Blood Pressure
- ☐ ☐ Chest pain on exercise
- ☐ ☐ Shortness of breath with mild exercise
- ☐ ☐ Irregular beat or palpitation of heart
- ☐ ☐ Pain or cramps in legs with exercise
- ☐ ☐ Swelling or edema of ankles
- ☐ ☐ History of Rheumatic Fever
  - Heart Attack
  - Enlarged Heart
  - Awaken at night with shortness of breath

Yes No

SKIN

- ☐ ☐ Rash
- ☐ ☐ Tumor on skin

BLADDER AND KIDNEY

- ☐ ☐ Frequency, urgency or pain with urination
- ☐ ☐ Passed blood or kidney stone
- ☐ ☐ Trouble starting or stopping of urinary stream
- ☐ ☐ Getting up at night to urinate more than twice
- ☐ ☐ Prostate disease
- ☐ ☐ Have you had a venereal disease

STOMACH AND BOWELS

- ☐ ☐ Trouble swallowing
- ☐ ☐ Abdominal pain, nausea, vomiting
- ☐ ☐ Foods disagree with you
- ☐ ☐ Stomach ulcer/Duodenal ulcer
- ☐ ☐ Vomit blood/Black bowel movement
- ☐ ☐ Diarrhea
- ☐ ☐ Constipation
- ☐ ☐ Hemorrhoids or rectal itching
- ☐ ☐ Blood or mucus in the stool
- ☐ ☐ Hernia or operated hernia
- ☐ ☐ Liver disease
- ☐ ☐ Hepatitis
- ☐ ☐ Jaundice

MUSCLES AND BONES

- ☐ ☐ Backache
- ☐ ☐ Pain or aching in feet or arches
- ☐ ☐ Numbness or tingling anywhere
- ☐ ☐ Pains or swelling of joints
- ☐ ☐ Arthritis

Yes No

ENDOCRINE

- ☐ ☐ Increased thirst, hunger
- ☐ ☐ Sudden weight change
- ☐ ☐ Sensitive to heat/cold
- ☐ ☐ Change in skin, body hair
- ☐ ☐ Change is sex drive

MISCELLANEOUS

- ☐ ☐ Disturbance of sleep
- ☐ ☐ Dizzy spells, headaches or fainting
- ☐ ☐ Are you depressed
- ☐ ☐ Excessive fatigue or nervousness
- ☐ ☐ Convulsions or been unconscious
- ☐ ☐ Tumor or cancer
- ☐ ☐ Anemia or difficulty with bleeding
- ☐ ☐ Sexual problems
- ☐ ☐ Have you considered suicide
- ☐ ☐ Excessive worry
- ☐ ☐ Other Important Health Information not noted above_____

_____

_____

_____

FEMALE

- ☐ ☐ Pain, irregular or excessive bleeding
- ☐ ☐ Date of last period _____
- ☐ ☐ Bleeding after menopause
- ☐ ☐ Discharge from vagina
- ☐ ☐ Children How many _____
- ☐ ☐ Breasts Lumps, soreness, discharge
- ☐ ☐ Any problems with pregnancies

REMARKS

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: _____

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