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
☐ Asian
☐ Other Race
☐ Black/African American
☐ Native Hawaiian Or Pacific Islander
☐ American Indian/Alaskan

ETHNIC ORIGIN
☐ Hispanic
☐ Non-Hispanic

Language _____

ADDRESS _____
CITY _____
ZIP CODE _____ 4 DIGIT _____
COUNTRY _____
EMPLOYER _____
WORK PHONE _____EXT _____

ADDRESS 2 _____
STATE _____
COUNTY _____
MARITAL STATUS _____
ADDRESS _____
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 _____ STATE _____ ZIP _____

POLICY HOLDER INFO

NAME _____
RELATIONSHIP TO PATIENT _____
SS# _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
DATE OF BIRTH _____
EMPLOYER _____
ADDRESS _____
CITY _____ STATE _____ 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 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 _____

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)

❑Allergies
❑Anemia
❑Anxiety
❑Arthritis (Type_____)
❑Asthma
❑Atrial Fibrillation
❑Enlarged Prostate (BPH)
❑Blood Clots/Clotting Disorder
❑Cancer (Type _____)
❑COPD/Emphysema
❑Coronary Artery Disease/Stents
❑Depression
❑Diabetes (Type 1 or 2)
❑High Cholesterol
❑GERD/Reflux
❑Headaches/Migraines
❑Heart Disease/Heart Failure
❑Hepatitis/Liver Disease
❑High Blood Pressure
❑Irritable Bowel
❑Heart Attack
❑Osteoporosis
❑Kidney Disease
❑Seizures
❑Stroke
❑Thyroid disease
❑Parkinson's Disease
❑Sleep Apnea
❑Substance Abuse
❑Tuberculosis
❑Dementia
❑HIV/AIDS
❑Fibromyalgia
❑Lupus

Women Only:
❑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_____ 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
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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