



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)				



AUTHORIZATION for USE and/or DISCLOSURE of
PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information, as set forth below. 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. **This authorization will remain in place until a notice of change is provided in writing.**

Patient Information (please print):

Name: _____

Date of Birth: _____

Protected Health Information to Be Used and/or Disclosed:

I authorize Wilmington Health to discuss medical information regarding my care, test results, appointments and/or billing information with someone other than myself? Yes No

If yes, I authorize Wilmington Health to disclose my protected health information to the following individuals, who may be contacted directly by Wilmington Health:

	NAME	RELATIONSHIP	PHONE NUMBER
1			
2			
3			

I authorize Wilmington Health to leave a message regarding my medical care on my voicemail Yes No
If yes, please provide the phone number: _____

I authorize Wilmington Health to send appointment reminders via Text Message? Yes No

If yes, please provide the phone number: _____
Please note data charges may apply per your cell phone carrier

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

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