



WILMINGTON HEALTH

Patient Information

Account No. _____

Doctor's No. _____

PLEASE ANSWER ALL QUESTIONS

PATIENT INFORMATION

NAME: LAST _____ FIRST _____ MIDDLE _____

BIRTHDATE _____ SS# _____ SEX _____ RACE _____ ETHNIC ORIGIN _____

HOME PHONE _____ M White/Caucasian Black/African American Hispanic

CELL PHONE _____ F Asian Native Hawaiian or Pacific Islander Non-Hispanic

EMAIL ADDRESS _____ Other Race American Indian/Alaskan

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 _____ 2) INSURANCE CO _____

ADDRESS _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ CITY _____ STATE _____ ZIP _____

MEDICARE/ID# _____ MEDICARE/ID# _____

GROUP # _____ GROUP # _____

POLICY HOLDER INFO

NAME _____ NAME _____

RELATIONSHIP TO PATIENT _____ RELATIONSHIP TO PATIENT _____

SS# _____ SS# _____

ADDRESS _____ ADDRESS _____

CITY/STATE/ZIP _____ CITY/STATE/ZIP _____

DATE OF BIRTH _____ DATE OF BIRTH _____

EMPLOYER _____ EMPLOYER _____

ADDRESS _____ ADDRESS _____

CITY _____ ST _____ ZIP _____ CITY _____ ST _____ ZIP _____

POLICY HOLDER INFO

(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: _____
AGE: _____

DATE: ____/____/____
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 or 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: _____



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 for USE, DISCLOSURE and/or
REQUEST of PROTECTED HEALTH INFORMATION**

1920 South 16th Street
Wilmington, NC 28401

Phone: 910-341-3308

Fax Release Form to: 910-341-3419

Fax Records to: 910-341-1900

SECTION A: Psychotherapy Notes. Check if this authorization is for psychotherapy notes. If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information. Identify the psychotherapy notes by checking "Other" in Section C and describing in the space provided, do not check any other boxes or types of information.

SECTION B: The Individual (or the Individual's Personal Representative) confirming the authorization. I authorize the use and/or disclosure of my protected health information as described in Section C 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.

Patient's Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Telephone: _____ **E-mail:** _____

Date of Birth: _____ **Social Security # (last 4 digits only):** _____

SECTION C: The use, disclosure and/or request being authorized (minimum necessary).

- Present year only 1 year 2years **History/Office Notes**
- Present year only 1 year 2years **Labs**
- Last **Eye Exam** Last **Foot Exam**
- 2 years **Pap Smears** 2 yrs **Mammograms** All **Immunization** summaries
- All **Colonoscopy** and **EGD** procedure reports All **Pathology** reports
- All **Radiologic studies (Bone Density, CT/CTA, MRI/MRA, US, Vascular, etc)**
- All **Cardiac Studies**
- All **Hospital Admissions, H&Ps, Consults, Operative reports, Discharges**
- Other (Please be specific and DO NOT request ALL Records)**

Entities Authorized to Use or Disclose:

Records requested **FROM:**

Name of provider/organization:

Address _____

Phone #: _____

Fax #: _____

Entities Authorized to Receive and Use:

Records to be **SENT TO:**

Name of provider/organization/person:

Address _____

Phone #: _____

Fax #: _____

SECTION D: Preference for Receipt of Records

- Regular Mail Fax:# _____ (Maximum 50 pgs)
- Pick up by: _____ (2-3 day processing minimum) Where: _____
- Retrieve from Website (Personal copies only)
- Electronic Copy (disk)

SECTION E: Purpose of Use, Disclosure and/or Request of Protected Health Information

- Personal Use ***You will be charged a state regulated fee for a personal copy of your records (\$10 minimum/\$50 maximum).**
- Changing Provider/Continuity of Care Insurance Attorney
- Other _____

SECTION F: Expiration

- This authorization will expire (**complete one**): 2 Years after my death
- Until I revoke permission in writing Future Date ____/____/____
- On the occurrence of the following event:

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Wilmington Health Privacy Officer **Telephone:** (910) 796-7701
Fax: (910) 341-3419 **Address:** 1920 South 16th Street, Wilmington, NC 28401
E-mail: privacy@wilmingtonhealth.com

Inability to Condition Treatment: I understand that Wilmington Health may not condition my treatment on my refusal to sign this authorization.

SECTION F: SIGNATURE

SIGNATURE—YOU MAY REFUSE TO SIGN THIS AUTHORIZATION AND THE REQUEST WILL BE CONSIDERED NULL & VOID.

PERSONAL COPIES WILL INCUR A FEE. REFER TO “SECTION E” FOR INFORMATION.

Signature: _____ **Date:** _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative’s Name: _____

Relationship to Individual: _____

WITNESS: _____ **Date:** _____

**YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.
Include this authorization in the individual’s medical record.**