WILMINGTON HEALTH

Account No._____
Doctor's No. _____

PLEASE ANSWER ALL QUESTIONS

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 _____ ☐ Other Race ☐ American Indian/Alaskan

ADDRESS _____ ADDRESS 2_____
CITY _____ STATE_____
ZIP CODE _____4 DIGIT_____ COUNTY_____
COUNTRY_____ MARITAL STATUS _____
EMPLOYER _____ ADDRESS _____
WORK PHONE _____EXT_____ PRIMARY CARE DOCTOR _____

RESPONSIBLE PARTY (Patients 18 years of age or younger)

NAME _____ BIRTHDATE _____ HOME PHONE _____ CELL PHONE _____
ADDRESS _____ CITY _____ STATE _____ ZIP_____ SS#_____
EMPLOYER_____RELATIONSHIP_____ MARITAL STATUS _____ SEX_____
ADDRESS_____ CITY _____ STATE _____ ZIP _____ PHONE _____

MOTHER (Patients 18 years of age or younger)

NAME _____ BIRTHDATE _____ HOME PHONE _____ CELL PHONE _____
ADDRESS _____ CITY _____ STATE _____ ZIP_____ SS#_____
EMPLOYER_____ MARITAL STATUS _____ SEX_____
ADDRESS_____ CITY _____ STATE _____ ZIP _____ PHONE _____

FATHER (Patients 18 years of age or younger)

NAME _____ BIRTHDATE _____ HOME PHONE _____ CELL PHONE _____
ADDRESS _____ CITY _____ STATE _____ ZIP_____ SS#_____
EMPLOYER_____ MARITAL STATUS _____ SEX_____
ADDRESS_____ CITY _____ STATE _____ ZIP _____ PHONE _____

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 **POLICY HOLDER INFO**

NAME_____ NAME_____
RELATIONSHIP TO PATIENT _____ RELATIONSHIP TO PATIENT _____
SS#_____ SS#_____
DATE OF BIRTH _____ DATE OF BIRTH _____
EMPLOYER _____ EMPLOYER _____
ADDRESS _____ ADDRESS _____
CITY _____ ST _____ ZIP _____ 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) I authorize my insurance carrier to release information regarding my coverage to Wilmington Health. I also authorize agents of any hospital, treatment center or previous physicians to furnish copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within Wilmington Health. (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 _____

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: _____

Patient Information Questionnaire

Name:_____ **Phone #:**_____ **Today's Date:**_____

DOB:_____ **Age:**_____ **Referred by:**_____

Please Provide The Following Information

General Information

What is your primary reason for coming to see us today? Routine Exam Other _____

How many times have you been pregnant? _____

Gynecologic and Obstetric Review:

If you have menstrual periods, when did your last menstrual period start? _____

If you do not have periods, please answer the following

Have you had a hysterectomy? Y N **Have you been through menopause?** Y N

Have you had your ovaries removed? Y N **Do you take hormone medication?** Y N

Are you presently sexually active? Y N **Have you ever been sexually active?** Y N

Do you plan a pregnancy in the near future? Y N

What are you using to prevent pregnancy? Nothing Condoms Diaphram Pills Shots Implants IUD
Tubal Ligation Vasectomy Other _____

Do you want to continue your present method? Y N

OB/GYN Review of Systems:

Have you ever had gonorrhea, Chlamydia, herpes, genital warts or other sexually transmitted disease? Y N

Do you want to be tested for sexually transmitted diseases today? Y N

Have you ever experienced problems with your breasts or pelvic organs? Y N

Have you had any GYN or abdominal surgery? Y N

Do you have:

Breast Problems Breast Pain Breast Lumps Nipple Discharge Abdominal Pain Pelvic Pain Genital Pain
Heavy Periods Painful Periods Irregular Periods Leakage of Urine Abnormal Vaginal Discharge Sexual Problems
Infertility Abnormal Body Hair Other Problems _____

General Medical Review of Systems:

Did you have any serious illness as a child? Y N

Have you had problems with:

Fevers	Night Sweats	Eyes/Vision	Ears/Nose/Throat	Heart	Chest Pain	Blood Pressure
Lungs	Breathing	Stomach	Ulcers	Liver	Gallbladder	Bowels
Kidneys	Bladder	Back/Spine	Blood	Bruising	Diabetes	Thyroid
Headaches/Migraines	Seizures/Convulsions		Stroke	Blood Clots in Veins or Lungs		
Varicose Veins	Skin	Muscle Disorders	Cancer		Mental Illness	

Social and Family History:

What is your marital status? S M D W **Where do you work?**_____

What is your job? _____

Do you smoke or use tobacco? Y N **If "yes" how many per day?**_____

Do you drink alcohol? Y N **If "yes" how many drinks per day?**_____

Have you ever used street drugs? Y N **If "yes" when was the last time?**_____

Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by anyone? Y N

Within the last year, has anyone forced you to have any sexual activities? Y N

Since your Last Visit, has anyone in your family developed:

Colon Cancer	Breast Cancer	Ovarian Cancer
Diabetes	Heart Disease	Tuberculosis
Birth Defects	Bleeding Disorders	Mental Illness

Are you up to date on your immunizations? Y N
