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 _____

****Please complete this form in its entirety (including dates when asked). This will help us to create your patient chart and to better serve your healthcare needs during your first visit. Please return forms at least 3 days prior to your scheduled new patient appointment. Also, please request records from your former primary care doctors and any specialty doctors prior to your appointment. ****

MEDICAL DATA SHEET

(For patients 18 years of age and older)

Name:	**Date:**
Age:	**DOB:**

Reason for visit: What is the main reason you are seeking a physician's advice? Do you have any current problems/concerns?_____

Pharmacy: Please list name and address of your local pharmacy and/or the name of any mail order pharmacy._____

Screening Summary:

Are you a current or a former smoker? If so, please include type/ amount smoked/age started and stopped.

Do you drink caffeine? If so, please include type and amount consumed per day.

Do you drink alcohol? If so, please include amount consumed per week._____

Do you use any illicit drugs? If so, please include type and the amount consumed:_____

Please list all allergies:
Drug Allergies:_____
Other Allergies (ex. food/environmental):_____

Medications: Please list all medications you are presently taking. **PLEASE include doses and directions/frequency.** Please include all over the counter meds as well (ex. Pain relievers/vitamins). **Please bring bottles with you to your appointment.**

Medication Name & Dose	**How Often?**	**Medication Name & Dose**	**How Often?**
1.		**8.**	
2.		**9.**	
3.		**10.**	
4.		**11.**	
5.		**12.**	
6.		**13.**	
7.		**14.**	

Name:	**DOB:**

Family History: List health information for family members (examples: any cancer/diabetes/heart disease/thyroid disease/lung disease/high blood pressure/kidney disease/blood disorder/nervous disorder/emotional disorders/any other disease processes). Please include age disease attained and whether the family member is deceased (age)?

Father:	Grandparents (Please indicate: Maternal or Paternal)
Mother:	Children:
Brother:	Aunts: (Please indicate: Maternal or Paternal)
Sister:	Uncles: (Please indicate: Maternal or Paternal)

Social History: What do you do for a living or are you retired? _____

_____

Past Medical History:

Please list ALL surgeries you have had, including dates performed:_____

_____

_____

Previous or Current Physicians

Physician	Specialty (i.e. Cardiology)	Diagnosis Treated

** If more space is needed, please use the back of this sheet.

Please list ALL medical conditions you have, including the conditions for any medicine you are currently taking. (ex. heart disease, high blood pressure, thyroid disease, diabetes, any cancer, lung disease, kidney disease, blood disorders, emotional disorders)_____

_____

_____

Name:	**DOB:**

Diagnostic Testing:

Please indicate if you have had the following testing, most recent date performed, and if the results were normal/abnormal.

Test	Date Performed?	Normal or Abnormal?
Colonoscopy		
Pap Smear (If applicable)		
Mammogram (If applicable)		
Bone Density (If applicable)		
PSA (If applicable)		
EKG		
TB Skin Test		

Immunizations:

Please call your previous healthcare provider to complete this portion if you are unsure of this information. Dates of last immunization as well as type are very important in order to better serve your healthcare needs during your first visit.

Immunization	Last Date Administered?
Flu	
Tdap (Tetanus with Pertussis / Whooping Cough)	
Td (Tetanus)	
Prevnar 13	
Pneumovax 23	
Zostavax (Shingles)	
HPV/Gardasil (If under 27 years old)	

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: _____