WILMINGTON HEALTH

Pediatric Patient Information (Patient less than 18 years old)

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 _____

RESPONSIBLE PARTY

NAME _____ BIRTHDATE _____ HOME PHONE _____ CELL PHONE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____ SS# _____
EMPLOYER _____ RELATIONSHIP _____ MARITAL STATUS _____ SEX _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____

MOTHER

NAME _____ BIRTHDATE _____ HOME PHONE _____ CELL PHONE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____ SS# _____
EMPLOYER _____ RELATIONSHIP _____ MARITAL STATUS _____ SEX _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____

FATHER

NAME _____ BIRTHDATE _____ HOME PHONE _____ CELL PHONE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____ SS# _____
EMPLOYER _____ RELATIONSHIP _____ MARITAL STATUS _____ SEX _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____

INSURANCE INFORMATION

1) INSURANCE CO _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
MEDICARE/ID# _____
GROUP# _____

POLICY HOLDER INFO

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

2) INSURANCE CO _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
MEDICARE/ID# _____
GROUP# _____

POLICY HOLDER INFO

NAME _____
RELATIONSHIP TO PATIENT _____
SS# _____
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 _____

FORM#15
Revision 08-2010

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: _____