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 ☐ Black/African American ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Other Race ☐ American Indian/Alaskan

ETHNIC ORIGIN ☐ Hispanic ☐ Non-Hispanic

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 _____

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 _____ ST _____ ZIP _____

POLICY HOLDER INFO

NAME _____

RELATIONSHIP TO PATIENT _____

SS# _____

ADDRESS _____

CITY/STATE/ZIP _____

DATE OF BIRTH _____

EMPLOYER _____

ADDRESS _____

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) 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 _____

AUTHORIZATION for USE and/or DISCLOSURE of PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information as described in Section B 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.

Section A: Patient Information (please print):

Name: _____

Address: _____

Account Number: _____ Social Security Number: _____

Date of Birth: _____ Telephone:_____

Section B: Protected Health Information to Be Used and/or Disclosed:

Do you wish for us to discuss all your protected health information with your family/friends or do you prefer that only specific information be released?

☐ All medical information, except psychotherapy information.

☐ 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.

☐ Specific information (please describe): _____

_____

Entities Authorized to Use or Disclose: Wilmington Health

Families, Friends and Other Authorized to receive and Use: (please name specifically any family/friends to which we may release your protected health information either in writing or verbally):

_____ _____

_____ _____

SECTION D: Purpose of Use or Disclosure of Protected Health Information.

☐ So family member, friend or caregiver may have knowledge of or assist in my medical care or payment for medical care.

☐ At the request of the individual

☐ Other:_____

SECTION E: Expiration

This authorization will expire (complete one):

☐ Until I revoke permission in writing

☐ On the occurrence of the following event:_____

☐ 2 Years after my death

☐ Future Date ____/____/

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) 772-1307 **Address:** 1202 Medical Center Drive, 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.

Voicemail and Text Message Notifications

If you would like for us to leave medical information regarding your care (i.e. lab results) or appointments on an answering machine please complete the section below.

Wilmington Health may leave a message regarding my medical information on the answering machine at this number (_____)_____-_____

**Wilmington Health may send appointment reminders via text message to the following number (_____)_____-_____

☐ Wilmington Health may not communicate appointment reminders via text message

** Text messaging is an offered service, however not required for appointment reminder notification. Note Text messaging charges may apply, based on your service contract with your service provider.

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—YOU MAY REFUSE 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: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

Include this authorization in the individual's medical record.

PERSONAL HISTORY

Name: Date:

Address: Chart No.:

P.O. Box Zip:

Doctor:

Family or Referring Physician:

Current Medical Problem:

Illnesses:

Diabetes	Liver Disease	Kidney Disease	Stroke	Seizures
Asthma	Hypertension	Alcoholism	TB	Cancer
Heart Disease	Lung Disease	Ulcers	Gallstones	Other
Jaundice				

Previous Surgery:

Date Surgery Doctor

Previous Medical Problems (if any):

Allergies: Medicines:

Other:

Social History:

Marital status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Use of alcohol: Never _____ Rarely _____ Moderate _____ Daily _____

Use of tobacco: Never _____ Previously, but quit _____ Current packs/day _____

Use of drugs: Never _____ Type/Frequency _____

Excessive exposure at home or work to: Fumes _____ Dust _____ Solvents _____ Air-borne particles _____ Noise _____

FAMILY HISTORY	Sex	If Living		If Deceased	
		Age	Health	Age at Death	Cause
Father					
Mother					
Brothers/Sisters* *(Circle Sex)*					
	M F				
	M F				
	M F				
	M F				
	M F				
Husband/Wife					
Sons/Daughters* *(Circle Sex)*					
	M F				
	M F				
	M F				
	M F				
	M F				

*Since some names may be used for either men or women, please circle sex for each Brother, Sister, Son or Daughter.

Do you know of any blood relatives who have or have had: (Circle and give relationships)

Stroke	_____	Epilepsy	_____	Heart Attack	_____	Nervous Breakdown	_____
Cancer	_____	Suicide	_____	Stomach Ulcers	_____	Rheumatic Fever	_____
High Blood Pressure	_____	Migraine	_____	Kidney Disease	_____	Insanity	_____
Tuberculosis	_____	Asthma	_____	Goiter	_____	Congenital Heart	_____
Diabetes	_____	Hay Fever	_____	Arthritis	_____		
Leukemia	_____	Bleeding Tendency	_____	Colitis	_____		

Form #460

PLEASE REVIEW THE FOLLOWING LIST OF MEDICAL PROBLEMS AND CIRCLE THE APPROPRIATE ANSWER. THANK YOU.

System Review:

***CONSTITUTIONAL SYMPTOMS**

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

*** EYES**

Eye disease or injury	No	Yes
Wear glasses/contact lens	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes

*** EARS/NOSE/MOUTH/THROAT**

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problem or rhinitis	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

*** CARDIOVASCULAR**

Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Shortness of breath with walking or lying flat	No	Yes
Swelling of feet, ankles or hands	No	Yes

*** RESPIRATORY**

Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

*** GASTROINTESTINAL**

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements or constipation	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain or heartburn	No	Yes
Peptic ulcer (stomach or duodenal)	No	Yes

*** GENITOURINARY**

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change in force of strain when urinating	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Male - testicle pain	No	Yes
Female - pain with periods	No	Yes
Female - irregular periods	No	Yes
Female - vaginal discharge	No	Yes

Female -# pregnancies ____ # miscarriages ____

Female - date of last pap smear _____

*** MUSCULOSKELETAL**

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

*** INTEGUMENTARY (skin, breast)**

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

*** NEUROLOGICAL**

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes
Head injury	No	Yes

*** PSYCHIATRIC**

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

*** ENDOCRINE**

Glandular or hormone problem	No	Yes
Thyroid disease	No	Yes
Diabetes	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming drier	No	Yes
Change in hat or glove size	No	Yes

*** HEMATOLOGICAL/LYMPHATIC**

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

*** ALLERGIC/IMMUNOLOGIC**

History of skin reaction to:

Penicillin or other antibiotics	No	Yes
Morphine, Demerol, or other narcotics	No	Yes
Novocaine or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxin or other serums	No	Yes
Iodine, methiolate or other antiseptic	No	Yes

Other drugs/medications_____

Known food allergies_____