Office Use Only – Recorded/Verified By: _____ Date: _____

City Employees/dependents who have received a physical exam by an outside medical provider (3/1/22-9/2/22) and wish to submit records in lieu of in-person Health Risk Assessment may complete this form and have their primary care provider complete the health risk assessment portion (page 4).

Please fax all documentation to fax number **910-395-3990** by September 2, 2022.

Patient Information

Last Name: _____ Suffix: _____ First: _____ Middle: _____

SSN: _____ Birthdate: _____ Sex: _____

Race: _____ Preferred Language: _____ Ethnicity: _____

Contact Information

Mailing Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____ Day Phone: _____

Email: _____ (Required field to enroll in patient portal. HRA results will be sent via the patient portal).

Employee Status: ☐ Employee ☐ Dependent

If you are a Dependent of an Employee:

What is your relationship to the Employee? ☐ Spouse ☐ Child ☐ Other: _____

Employee's SSN: _____

Primary Care Provider: _____ Provider's City/State of Practice: _____

	None	1-2 Times	3-5 Times	5+ Times
In the past year, how many times have you been to a doctor's office?	☐	☐	☐	☐
In the past year, how many times have you been to an Emergency Room?	☐	☐	☐	☐
In the past year, how many times have you been admitted to the hospital?	☐	☐	☐	☐

When was your last physical exam with a Health Care Provider?

☐ One Year or Less
☐ More Than One Year
☐ More Than Two Years

Continue to next page

Patient Name: _____ Date of Birth: _____

Tobacco Use (e.g., cigarettes, cigars, snuff, e-cigarettes/vaping pens): ☐ Current User ☐ Former User ☐ Never Used

Type Used: _____ Amount Per Day: _____

# of Years Used: _____ Year Quit Use: _____

What is your willingness to quit? ☐ Not Ready to Quit ☐ Considering Quitting ☐ Ready to Quit

Are you satisfied with your daily nutrition and eating habits? ☐ Yes ☐ No

Over the past three months, how much of an impact do you think your health has affected your productivity at work?

☐ Has Had No Impact ☐ Has Had a Little Impact ☐ Has Had Significant Impact

How many days of work have you missed in the past year as a result of an illness?

☐ None ☐ Less Than 1 Week ☐ Less Than 2 Weeks ☐ More Than 2 Weeks

How many hours of sleep do you get in an average night?

☐ Less Than 4 Hours ☐ 4-6 Hours ☐ 7-8 Hours ☐ More Than 8 Hours

How would you describe your overall mental stress level?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

How willing are you to make changes to improve your health?

☐ I don't feel that I need to make changes related to my health.

☐ I am not willing to make change to impact my health.

☐ I know that changes are needed to improve my health, but not sure how to begin.

☐ I am aware of my health risks and have a strong desire to improve my overall health.

By signing this document, I hereby knowingly and voluntarily:

- Authorize Wilmington Health, the on-site practitioner, the clinic reference laboratory processing my blood specimens, and my employer's Health Plan Administrator to collect and disclose my individually identifiable health information, including any genetic information (such as my family history), for the purposes of rendering care in the Wilmington Health Clinic or as otherwise contemplated by the Notice of Privacy Practices; and,
- Consent to the receipt of automated health information outreach texts and voice messages, understanding that I may revoke my consent at any time by notifying my Wilmington Health on-site practitioner or opting out in response to a text or other message I receive. I understand my mobile carrier may charge for the receipt of these messages.

_____ _____

Patient Signature **Date**

If you have a **Wilmington Health PCP who has completed a physical with the labs needed, you only need to complete page 1, 2 and check the box below. When you fax in this document, we will verify the information in your medical record and send HRA results via your patient portal.**

☐ I have a WH PCP who has completed exam and all labs between 3/1/22 and 9/2/22

AUTHORIZATION for USE and/or DISCLOSURE of
PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information, as set forth 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. **This authorization will remain in place until a notice of change is provided in writing.**

Patient Information (please print):

Name: _____

Date of Birth:_____

Protected Health Information to Be Used and/or Disclosed:

I authorize Wilmington Health to discuss medical information regarding my care, test results, appointments and/or billing information with someone other than myself? ☐**Yes** ☐**No**

If yes, I authorize Wilmington Health to disclose my protected health information to the following individuals, who may be contacted directly by Wilmington Health:

	NAME	RELATIONSHIP	PHONE NUMBER
1			
2			
3			

I authorize Wilmington Health to leave a message regarding my medical care on my voicemail. ☐**Yes** ☐**No**
If yes, please provide the phone number:_____

I authorize Wilmington Health to send appointment reminders via Text Message? ☐**Yes** ☐**No**
If yes, please provide the phone number:_____
Please note data charges may apply per your cell phone carrier

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: _____

Health Risk Assessment - To Be Completed by a Medical Provider Only

Patient Name: _____ Date of Birth: _____

Assessment Date: _____

☐ Blood draw attempt unsuccessful; no specimen taken.

☐ Copy of blood analysis provided in lieu of blood draw and attached.

Weight (lbs.): _____ Height: _____(feet) _____(inches)

Waist Circumference: _____ (inches) Body Fat: _____%

Biometric	**Patient Results**
Body Mass Index (BMI)	
Blood Pressure (Systolic and Diastolic)	
Total Cholesterol (mg/dL)	
HDL Cholesterol (mg/dL)	
LDL Cholesterol (mg/dL)	
Triglycerides (mg/dL)	
Hemoglobin A1C	
Blood Glucose (mg/dL)	

By signing below, I verify that I have conducted a medical exam, assessment or testing to obtain the above information between March 1, 2022 and date on signature line.

Physician Name: _____ Practice Name: _____

Physician Signature: _____Date: _____

Please Fax Completed Forms to Wilmington Health Direct – City of Wilmington at:
Fax Number: 910-395-3990