TRUE Care

WELCOME TO WILMINGTON HEALTH **TRUE CARE**

Thank you for your trust in Wilmington Health. **Please fill out and submit the enclosed forms two days before your appointment to help us provide the best care possible**. We look forward to serving you!

WHY CHOOSE WILMINGTON HEALTH?

At Wilmington Health, it starts with **Trust**, at a place that **Respects** you. Where expert care meets **Unmatched** value. And where a collaborative, **Empowering** approach to wellness is not only our top priority, it’s also our promise to you. Since 1971, no other area provider has offered better, more affordable care than Wilmington Health. We call it TRUE Care.
And it’s what we offer our patients every single day.

WILMINGTONHEALTH.COM

Demographics

Please print, complete all fields, and sign.

Office Use Only: Recorded By: ________________ Date: ____________

Patient Last Name________________________________ Suffix______ First___________________________ Middle____________

Prior Last Name____________________Nickname______________SSN_____________Birthdate__________ Male___ Female_____

Billing or PO Box Address

Street______________________________ Apt/Bldg/Lot_______

City______________________ State______ Zip___________

County______________ Country: US_____ Other___________

Secondary or Physical Address

Street______________________________ Apt/Bldg/Lot_______

City______________________ State______ Zip___________

County______________ Country: US: _____Other___________

Primary Care Provider____________________ Marital Status__________ Race___________ Language__________ Ethnicity___________

1-Primary Insurance Name ___________________________

Policy ID#___________________________ Group#__________

Insurance Address_____________________________________

City______________________ State_________ Zip__________

Policy Holder (Sponsor) Name___________________________

Birthdate_____________ Sex_____ Phone_______________

Street ______________________________ Apt/Bldg/Lot_____

City_________________________ State______ Zip_________

Policy Holder's Relationship to Patient_____________________

Employer____

2-Secondary Insurance Name ___________________________

Policy ID#___________________________ Group#__________

Insurance Address_____________________________________

City______________________ State_________ Zip__________

Policy Holder (Sponsor) Name___________________________

Birthdate_____________ Sex_____ Phone_______________

Street ______________________________ Apt/Bldg/Lot_____

City_________________________ State______ Zip_________

Policy Holder's Relationship to Patient_____________________

Employer____

Patient Contact Information

Home Phone__________________ Cell___________________

Day Phone___________________ Alternate________________

Preferred Contact (check 1) Home____ Cell____ Work____ Portal____

Preferred Notification (check 1) Phone___ Text___ Voice Reminders____

E-Mail________________________________ Decline E-Mail____

Patient Portal (check 1) Desires registration____ Already registered____

Mother/Parent 1 (of patient under 18)

First Name__________________ Middle___________________

Last__________________________ SSN___________________

Phone________________________ Birthdate________________

Street ______________________________ Apt/Bldg/Lot______

City____________________________ State______ Zip_________

E-Mail________________________________ Decline E-Mail____

Father/Parent 2 (of patient under 18)

First Name__________________ Middle___________________

Last________________________ Suffix____ SSN_____________

Phone________________________ Birthdate________________

Street ______________________________ Apt/Bldg/Lot______

City____________________________ State______ Zip_________

E-Mail________________________________ Decline E-Mail____

Emergency Contact Information

First Name___________________ Middle ___________Last_______________________ Relationship___________________

Street ____City_____________________________State__________Zip______________

Birthdate ______________________Home Phone ________________________Cell ___________________Work____________________

(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.

	Print Name	**Sign Name** (Signature Required)	**Relationship to Patient**	**Date**
Patient				
Responsible Party (Of Patient Under 18 Or HealthCare POA)				

A copy of this authorization and assignment shall be considered as valid as the original.

New Pediatric Patient Medical History Form

Date:______________ Child's Name:______________________________ Nickname:____________________________
Date of Birth: ______________ Sex: ☐Male ☐Female Gender:____
Previous Physician:_____________________________ Request for Records Transfer: ☐Yes ☐No
Last Well Child Exam Date:______________
Mother's/Parent 1 Full Name:____________________________________
Father's/Parent 2 Full Name:____________________________________
Step-Mother's/Step-parent 1 Full Name (if applicable):____________________________________
Step-Father's/Step-parent 2 Full Name (If applicable):____________________________________
Custodial Provider's Full Name (If different from above):____________________________________
Relationship to Patient:____________________________________

Birth History

☐Check here is unknown due to adoption
Birth Weight:_______ Pregnancy#:_______ Mom's Age:_______
Was birth: ☐Vaginal ☐Cesarean ☐Early ☐Late
If birth was early, how many weeks early?______________ If Cesarean, why?_____________________________
Did mother have any illnesses/problems with her pregnancy? ☐Yes ☐No Explain:______________________
Did baby have any problems right after birth? ☐Yes ☐No Explain:_____________________________________
Before mother knew she was pregnant or at any time during her pregnancy did she:
Smoke Cigarettes (amount):________________________ Drink Alcohol (amount):________________________
Use Street Drugs (type):________________________ Use Prescription Drugs (type):________________________
Patient exposed to secondhand smoke? ☐Yes ☐No Patient consumes caffeine? ☐Yes ☐No
Was initial feeding: ☐Breast Milk ☐Formula

Current and Past History

☐Check here if unknown due to adoption
Is your child currently on any medication? ☐Yes ☐No
Explain/List: ____
____
____

Does your child have any serious or chronic illnesses? ☐Yes ☐No Explain:________________________
Has your child had serious injuries or accidents? ☐Yes ☐No Explain:________________________
Has your child had any surgeries? ☐Yes ☐No Explain:________________________
Has your child ever been hospitalized? ☐Yes ☐No Explain:________________________
Is your child allergic to any medication/foods? ☐Yes ☐No Explain:________________________
Has your child ever reacted to an immunization? ☐Yes ☐No Explain:________________________

Does Your Child Have or Has Your Child Ever Had:
Asthma, recurrent cough, bronchitis, or pneumonia? ☐Yes ☐No Explain:________________________
Nasal allergies or eczema? ☐Yes ☐No Explain:________________________
Frequent ear infections or sore throat? ☐Yes ☐No Explain:________________________

New Pediatric Patient Medical History Form

Problems with ears or hearing? ☐Yes ☐No Explain:____________________
Problems with eyes, vision, or teeth? ☐Yes ☐No Explain:____________________
Frequent headaches or other neurological problems? ☐Yes ☐No Explain:____________________
Frequent abdominal pain? ☐Yes ☐No Explain:____________________
Constipation requiring doctor visits? ☐Yes ☐No Explain:____________________
Bladder/Kidney problems or bedwetting? ☐Yes ☐No Explain:____________________
Any heart problems/murmur? ☐Yes ☐No Explain:____________________
Anemia or bleeding problem? ☐Yes ☐No Explain:____________________
Thyroid or other gland problem? ☐Yes ☐No Explain:____________________
Diabetes? ☐Yes ☐No Explain:____________________
ADD/ADHD? ☐Yes ☐No Explain:____________________
Mental Health Issues? ☐Yes ☐No Explain:____________________
Use of Drugs or Alcohol? ☐Yes ☐No Explain:____________________

Household Information

Please List All Those Living in the Child's Home

Name:________________________ Relationship to Child:________________ DOB:________
Name:________________________ Relationship to Child:________________ DOB:________
Name:________________________ Relationship to Child:________________ DOB:________
Name:________________________ Relationship to Child:________________ DOB:________
Name:________________________ Relationship to Child:________________ DOB:________
Name:________________________ Relationship to Child:________________ DOB:________

Child Care:____
Smokers in household? ☐Yes ☐No Vaping? ☐Yes ☐No

Family Medical History

(Parents, Siblings, Maternal and Paternal Grandparents, Maternal and Paternal Aunts/Uncles
☐Check Here if Family History is Unknown

Have any Family Members Had the Following:

Alcohol/Drug Abuse? ☐Yes ☐No Who?____________ Comments: ____________________
Allergies? ☐Yes ☐No Who?____________ Comments: ____________________
Asthma? ☐Yes ☐No Who?____________ Comments: ____________________
Birth Defects? ☐Yes ☐No Who?____________ Comments: ____________________
Blood Disorders? ☐Yes ☐No Who?____________ Comments: ____________________
Bone Disorders? ☐Yes ☐No Who?____________ Comments: ____________________
Cancer? Type? ☐Yes ☐No Who?____________ Comments: ____________________
Diabetes? ☐Yes ☐No Who?____________ Comments: ____________________
Endocrine Disorder? ☐Yes ☐No Who? ____________ Comments: ____________________
Ear/Nose/Throat Disorders? ☐Yes ☐No Who?____________ Comments: ____________________
Eye Disorders? ☐Yes ☐No Who?____________ Comments: ____________________

New Pediatric Patient Medical History Form

Gastrointestinal Disorders? ☐Yes ☐No Who?______________ Comments: ______________________________
Heart Disease? ☐Yes ☐No Who?______________ Comments: ______________________________
High Blood Pressure? ☐Yes ☐No Who?______________ Comments: ______________________________
High Cholesterol? ☐Yes ☐No Who?______________ Comments: ______________________________
Immune Disorders? ☐Yes ☐No Who?______________ Comments: ______________________________
Joint Problems? ☐Yes ☐No Who?______________ Comments: ______________________________
Kidney Disease? ☐Yes ☐No Who?______________ Comments: ______________________________
Liver Disease? ☐Yes ☐No Who?______________ Comments: ______________________________
Lung Disease? ☐Yes ☐No Who?______________ Comments: ______________________________
Migraine Headaches? ☐Yes ☐No Who?______________ Comments: ______________________________
Metabolic Disorders? ☐Yes ☐No Who?______________ Comments: ______________________________
Obesity? ☐Yes ☐No Who?______________ Comments: ______________________________
Seizure Disorder? ☐Yes ☐No Who?______________ Comments: ______________________________
Skin Disorders? ☐Yes ☐No Who?______________ Comments: ______________________________
Stroke History? ☐Yes ☐No Who?______________ Comments: ______________________________
Thyroid Disorders? ☐Yes ☐No Who?______________ Comments: ______________________________
Mental Health History? ☐Yes ☐No Who?______________ Comments: ______________________________
Other Medical History? ☐Yes ☐No Who?______________ Comments: ______________________________

Vaccines: Please **bring the most recent vaccination record** to your appointment. Wilmington Health firmly believes in the effectiveness and safety of vaccines to prevent serious illness and save lives.

Vaccine information:____
____
____
____
____
____
____

1202 Medical Center Dr.
Attn: Medical Records
Wilmington, NC 28401
Phone: 910-341-3308
Fax Requests to: 910-341-3419
Fax Records to: 910-341-1900

Authorization for Use, Disclosure, and/or Request of Protected Health Information

Patient Name: ____

Date of Birth: ______________________ Phone Number: _____________________________

Address: ____

City: ___________________________ State: ___________ Zip Code: _________________________

Specific information being requested:

- ☐ All Pediatric records
- ☐ History/Office Notes
- ☐ Laboratory Test results
- ☐ Pap Smears
- ☐ Mammograms
- ☐ Immunizations
- ☐ Colonoscopy and/or EGD reports including associated Pathology reports
- ☐ Radiology reports (includes Bone Density, CT/CTA, MRI/MRA, Vascular, etc.)
- ☐ Cardiology Studies
- ☐ Other: (Please be as specific as we will only be able to provide the specific information you list)
  ____

Time Frame of records to be released: (examples: 1 year, 2016 – current, or last 3 visits)

____

Unless initialed the following information will NOT be released or disclosed:

______ HIV/AIDS/Communicable Disease Status

______ Alcohol and/or Drug Abuse or Treatment

______ Mental Health Status or Treatment

Entities Authorized to Use, Disclose, or Receive: If persons or organizations authorized 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.

Records Requested FROM: Where are the records coming from?	**Records Being Sent TO:** Where are the records being sent?
Name of Provider or Organization: ____________________________	Name of Provider or Organization: ____________________________
Address: ______________________ ____________________________	Address: ______________________ ____________________________
Phone: ________________________	Phone: ________________________
Fax: __________________________	Fax: __________________________

1202 Medical Center Dr.
Attn: Medical Records
Wilmington, NC 28401
Phone: 910-341-3308
Fax Requests to: 910-341-3419
Fax Records to: 910-341-1900

Preference for receipt of records:

- ☐ Regular Mail
- ☐ Fax: ______________________
- ☐ Electronic Copy (disk)

The purpose of the Use, Disclosure, and/or Request: Fees may apply based on form of and reason for release of information.

- ☐ Changing Provider/Continuation of Care
- ☐ Insurance
- ☐ Attorney
- ☐ Personal Use
- ☐ Other: ____

This Authorization will expire: (choose one)

- ☐ 2 years after death of patient
- ☐ Upon written revocation
- ☐ Future Date: _______________
- ☐ On the occurrence of the following event: ____________________________________

By signing below, I understand:

- I authorize the use and/or disclosure of my protected health information as described in this document.
- I may revoke this authorization at any time by providing written notice of my revocation. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before notice of revocation of authorization was received.
- I may refuse to sign this authorization and the request will be considered null and void.
- Wilmington Health may not condition my treatment on my refusal to sign this authorization.

Signature: ____

Date: ______________ Last 4 digits of patient's social security number: ________________

If this authorization is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____

Witness: _____________________________________ Date: ___________________________

If you have concerns about your privacy rights, please contact Wilmington Health Privacy Officer:
Phone: 910-796-7701 Fax: 910-772-1307 Address: 1202 Medical Center Dr. Wilmington, NC 28401
Email: privacyofficer@wilmingtonhealth.com

Office Use Only: Recorded By ______________________ Date: _______________

AUTHORIZATION TO CONSENT TO HEALTH CARE FOR MINOR

I, ____, of _______________________County, State of ________________________________, am the custodial parent having legal custody of _________________________________, a minor child, age ___________, born _____________________. I authorize _______________________________________ of ____________________________ County, State of ________________________________, to do any acts which may be necessary or proper to provide for the health care of the minor child, including but not limited to, the power (i) to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and (ii) to consent to and authorize any health care, including the administration of anesthesia, x-ray examination, performance of operations or other procedures by physicians, dentists, and other medical personnel, except the withholding or withdrawal of life-sustaining procedures.

This consent shall be effective from the date it is executed until the date I terminate it in writing.

By signing here I indicate that (i) I have the understanding and capacity to recognize the importance of, to communicate, and assign the health care decision covered by this document, (ii) I am fully informed as to the contents of the document, and (iii) I understand the full scope and importance of this grant of powers to the agent named herein.

____ ___________________________

Custodial Parent's Signature **Date**
(Witness Required if signed in Wilmington Health office)

____ ___________________________

WH Staff Signature as Witness **Date**
(of Custodial Parent's Signature if signed in Wilmington Health office)

Notary Public Required if signed outside of Wilmington Health office

STATE OF ______________________________

COUNTY OF ____________________________

On this ____________ day of ______________________, 20________, personally appeared before me the named ___________________________________, to me known and known to me to be the person described in and who executed to foregoing instrument and that person acknowledges that he or she executed the same and being duly sworn to me, made oath that the statements in the foregoing instrument are true.

______________________________________, Notary Public *(OFFICIAL SEAL)*

My Commission Expires: _____________________________

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: ____