WILMINGTON HEALTH
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.

Name:
DOB:
Chart:
Age:
Date:

PATIENT INTAKE

WILMINGTON HEALTH
ORTHOPAEDICS AND SPORTS MEDICINE

Patient's Name:

Last: _____ First: _____ Middle Initial: _____DOB: _____

Side of body: ☐ LEFT ☐ RIGHT

CURRENT PROBLEM:

Describe your current problem: _____

_____

_____

When did this problem begin? _____Date: _____

Were X-Rays taken? ☐ Yes ☐ No If yes, where were they taken?_____

Did you bring these X-Rays today? ☐ Yes ☐ No Were you seen in the Emergency Room by our Doctor? ☐ Yes ☐ No

Have you previously been treated by a physician in this practice? ☐ Yes ☐ No If yes, approximately when?_____

Were you injured in an accident? ☐ Yes ☐ No If yes, what type? ☐ Auto ☐ Work ☐ Other:_____

If accident related, describe how the injury occurred:_____

_____

_____

_____

_____

Do you have an attorney? ☐ Yes ☐ No If yes, Name:_____

Signature Authorizing Treatment: _____ Date:_____

INSURANCE ASSIGNMENT:

I, the undersigned, have insurance coverage and assign directly to Carolina Sports Medicine all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submission whether manual or electronic.

Signature of Insured/Guardian: _____ Date: _____

MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare benefits be made on my behalf to Carolina Sports Medicine for any services furnished me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, Carolina Sports Medicine agrees to accept the charge determination of the Medicare carrier as the full charge, and I am responsible for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature: _____ Date: _____

Wilmington Health Primary Care
Adult New Patient Health History Form

Name: _____ Date of Birth: _____ Email: _____

Local Pharmacy:_____ Mail order Pharmacy: _____

Reason for your visit today:_____

Previous/current physicians: _____

Personal Medical History -Please mark each of the following that applies to you (currently or in the past)

- ❑Allergies
- ❑Anemia
- ❑Anxiety
- ❑Arthritis (Type_____)
- ❑Asthma
- ❑Atrial Fibrillation
- ❑Enlarged Prostate (BPH)
- ❑Blood Clots/Clotting Disorder
- ❑Cancer (Type _____)
- ❑COPD/Emphysema
- ❑Coronary Artery Disease/Stents
- ❑Depression
- ❑Diabetes (Type 1 or 2)
- ❑High Cholesterol
- ❑GERD/Reflux
- ❑Headaches/Migraines
- ❑Heart Disease/Heart Failure
- ❑Hepatitis/Liver Disease
- ❑High Blood Pressure
- ❑Irritable Bowel
- ❑Heart Attack
- ❑Osteoporosis
- ❑Kidney Disease
- ❑Seizures
- ❑Stroke
- ❑Thyroid disease
- ❑Parkinson's Disease
- ❑Sleep Apnea
- ❑Substance Abuse
- ❑Tuberculosis
- ❑Dementia
- ❑HIV/AIDS
- ❑Fibromyalgia
- ❑Lupus

Women Only:

- ❑Abnormal PAP smear
- #_____ of Pregnancies
- #_____ of Children
- Last Menstrual Period _____

Other Medical Problems (not listed above) _____

_____

_____

Medication List - Please list currently prescribed medications and any supplements.

Medication Name	Dosage	How often?	30/90 day RX?	Refills needed?

Allergies - Please describe any allergic reactions to medications, foods, or the environment.

_____

_____

_____

Name: _____ **Date of Birth:** _____

Surgical History- If additional space is needed, please use back of sheet

Type of Surgery (example: hysterectomy)	**Date (year)**

Health Maintenance – Please bring a copy of your immunizations to your appointment.

	Date	**Results**
Colonoscopy		
Mammogram (women only)		
PAP smear (women only)		
DEXA (Bone density)		

Social History- What is your occupation? _____

Marital Status: ❑Married ❑Single ❑Divorced ❑Widowed ❑Life Partner

Who do you live with? _____

Tobacco Use ❑Current User ❑Never User ❑Former User
Type Used: _____ Amount per day: _____
# of Years used:_____ Quit Year _____

Alcohol Use ❑Current User ❑Never User ❑Former User
Type of alcohol: _____ How much per week:_____

Drug Use/Substance Abuse ❑Current User ❑Never User ❑Former User

Family History- Please indicate your family history in the boxes below
❑ Please check here if adopted (no family history available)

Biological Family Member	**Deceased?**	**List any medical problems (with age at diagnosis if known)**
Mother/Parent 1		
Father/Parent 2		
Sister(s)		
Brother (s)		
Daughter(s)		Ages:
Son(s)		Ages:
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Other relations		

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: _____

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