WILMINGTON HEALTH | 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

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.

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:_____

Patient Name: _____ DOB: _____

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: _____

Patient Name: _____ DOB: _____

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:	**Records Being Sent TO:**
Where are the records coming from?	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 (the following person)_____ 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

Office Use Only: Recorded By _____ Date: _____

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: _____