WILMINGTON HEALTH

Patient Information

PLEASE ANSWER ALL QUESTIONS

NAME: LAST _____ FIRST _____ MIDDLE _____

BIRTHDATE _____ SOC.SEC. # _____ SEX ☐ M ☐ F

PRIMARY PHONE _____

EMAIL _____

WORK PHONE _____ EXT _____

MARITAL STATUS _____

RACE

☐ White/Caucasian ☐ Black/African American

☐ Asian ☐ American Indian/Alaskan

☐ Native Hawaiian or Pacific Islander ☐ Other Race

ETHNIC ORIGIN

☐ Hispanic

☐ Non-Hispanic

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PRIMARY CARE DOCTOR _____

SPOUSE INFORMATION (IF ESTABLISHING)

NAME: LAST _____ FIRST _____ MIDDLE _____

BIRTHDATE _____ SOC.SEC. # _____ SEX ☐ M ☐ F

PHONE (IF DIFFERENT FROM INSURED _____

EMAIL _____

WORK PHONE _____ EXT _____

EMPLOYER _____

RACE

☐ White/Caucasian ☐ Black/African American

☐ Asian ☐ American Indian/Alaskan

☐ Native Hawaiian or Pacific Islander ☐ Other Race

ETHNIC ORIGIN

☐ Hispanic

☐ Non-Hispanic

ADDRESS (IF DIFFERENT FROM INSURED) _____

CITY _____ STATE _____ ZIP CODE _____

PRIMARY CARE DOCTOR _____

(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, test, medical equipment rentals, supplies and nursing/physical services including major medical 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 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 _____

OTHER DEPENDENTS

NAME: LAST _____ FIRST _____ MIDDLE _____

BIRTHDATE _____ SOC.SEC. # _____ SEX ☐ M ☐ F

PHONE (IF DIFFERENT FROM INSURED _____

EMAIL _____

PRIMARY CARE PROVIDER _____

RACE

☐ White/Caucasian ☐ Black/African American

☐ Asian ☐ American Indian/Alaskan

☐ Native Hawaiian or Pacific Islander ☐ Other Race

ETHNIC ORIGIN

☐ Hispanic

☐ Non-Hispanic

ADDRESS (IF DIFFERENT FROM INSURED) _____

CITY _____ STATE _____ ZIP CODE _____

NAME: LAST _____ FIRST _____ MIDDLE _____

BIRTHDATE _____ SOC.SEC. # _____ SEX ☐ M ☐ F

PHONE (IF DIFFERENT FROM INSURED _____

EMAIL _____

PRIMARY CARE DOCTOR _____

RACE

☐ White/Caucasian ☐ Black/African American

☐ Asian ☐ American Indian/Alaskan

☐ Native Hawaiian or Pacific Islander ☐ Other Race

ETHNIC ORIGIN

☐ Hispanic

☐ Non-Hispanic

ADDRESS (IF DIFFERENT FROM INSURED) _____

CITY _____ STATE _____ ZIP CODE _____

NAME: LAST _____ FIRST _____ MIDDLE _____

BIRTHDATE _____ SOC.SEC. # _____ SEX ☐ M ☐ F

PHONE (IF DIFFERENT FROM INSURED _____

EMAIL _____

PRIMARY CARE DOCTOR _____

RACE

☐ White/Caucasian ☐ Black/African American

☐ Asian ☐ American Indian/Alaskan

☐ Native Hawaiian or Pacific Islander ☐ Other Race

ETHNIC ORIGIN

☐ Hispanic

☐ Non-Hispanic

ADDRESS (IF DIFFERENT FROM INSURED) _____

CITY _____ STATE _____ ZIP CODE _____

WILMINGTON HEALTH

Portal Enrollment

Adult Patient or Parent/Guardian of Dependent Child (0-17 Years Old):

NAME: _____ **DOB:** _____

Email Address: _____

Security Question (Mother's Maiden Name): _____

Dependent Child Information 0-17 Year-Old Name: _____ DOB: _____ Gender: M/F	___WH Parent Already Registered (Print child's PIN/Give to parent) ___WH Parent Needs to be Registered (Register Parent/add Dependent) ___Parent is not a WH patient (Self-register on website/add Dependent) For Office Use Only - Pull Child's Account/Generate PIN/Print PIN (Enter child's generated PIN at Registration for immediate access)

Portal Log-in Instructions for Patients

- **Go to** www.wilmingtonhealth.com **, Patient Portal, Already Registered?** LOG-IN NOW!
- **Login with Email Address**
- **Use Temporary Password:** _____**wilmingtonhealth**_____
- **Security Question (Mother's Maiden Name)**

To Complete Enrollment, LOG-IN and Send us a Message saying "I am Enrolled in Portal":

◯ **For yourself**
◯ **On behalf of your child**

- **Download Portal App PatientPORTAL by InteliChart**

PatientPORTAL

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)

Family Member	**Deceased?**	**List any medical problems (with age at diagnosis if known)**
Mother		
Father		
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. 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.

Patient Information (please print):

Name: _____

Date of Birth: _____

Protected Health Information to Be Used and/or Disclosed:

Yes☐ **No**☐ May we discuss medical information regarding your care, test results, appointments or billing information with someone other than yourself? Please list any individuals you wish to have this permission.

	NAME	RELATIONSHIP
1		
2		
3		

Yes☐ **No**☐ May we leave a message regarding your medical care on your voicemail? If yes, please provide the phone number:_____

Yes☐ **No**☐ May we send you appointment reminders via Text Message? If yes please provide the phone number:_____
(Please note data charges may apply per your cell phone carrier)

Expiration: This authorization will remain in place until a notice of change is provided in writing

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: _____

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: _____