WILMINGTON HEALTH

Demographics

Please print, complete all fields, and sign.

Office Use Only: Recorded By _____ Date _____

Patient Last Name _____ Suffix _____ First _____ Preferred _____ Middle _____

Prior Last Name _____ Nickname _____ SSN _____ Birth date _____ 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 _____

Birth date _____ 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 _____

Birth date _____ 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 Contract (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's Information (if patient under 18)

First Name _____ Middle _____

Last _____ SSN _____

Phone _____ Birth date _____

Street _____ Apt/Bldg/Lot _____

City _____ State _____ Zip _____

E-mail _____ Decline E-Mail ☐

Father's Information (if patient under 18)

First Name _____ Middle _____

Last _____ SSN _____

Phone _____ Birth date _____

Street _____ Apt/Bldg/Lot _____

City _____ State _____ Zip _____

E-mail _____ Decline E-Mail ☐

Emergency Contact Information

First Name _____ Middle _____ Last _____ Relationship _____

Street _____ City _____ State _____ Zip _____

Birth date _____ 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 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.

WILMINGTON HEALTH

Patient Information Questionnaire

Name: _____ Preffered Name:_____Phone #: _____

Today's Date:_____ DOB:_____Age:_____ Pharmacy: _____

Number of pregnancies _____ ☐ Vaginal ☐ C-Section ☐ Full Term ☐ Preterm ☐ Ectopic ☐ Miscarriage

Living children _____ Have you had sexual activity of any kind in the last year? Yes ☐ No ☐

Allergies?_____

Please Provide the Following Information

General Information

What is your primary reason for coming to see us today? Routine Exam Other: _____

Gynecologic and Obstetrics Review:

If you have menstual periods, when did you last menstrual period start? _____

Please Anwer the Following Questions:

Have you had a Hysterectomy? Y N Have you been through menopause? Y N

Do you take hormone medication? Y N have you had your ovaries removied? Y N

Are you presently sexually active? Y N

Do you plan a pregnancy in the near future? Y N

What are you using to prevent pregnancy? Nothing Condoms Diaphragm Pills Shots Implant IUD
Tubal Ligation Vasectomy Other: _____

Do you want to continue your present method? Y N

OB/GYN Review of Systems:

Have you ever had Gonorrhea, Chlamydia, Herpes, Genital warts, or other STDs? Y N

Do you want to be tested for sexually transmitted diseases today? Y N

Have you experienced problems with your breast or pelvic organs? Y N

Do you currently have any of the following:

Breast Problems Sexual Problems Difficulty with periods Urine Leakage Painful periods

Discharge Night Sweats Abnormal body hair Other Problems: _____

General Medical Review of Systems:

Since your last visit, have you been diagnosed with any of the following:

Lung Disease Migraines Cancer Blood Pressure Issues Kidney Disease Stroke

Blood Clots Blood Clots in Veins or Lungs Mental Illness Heart Disease Diabetes

Social and Family History:

What is your marital status? S M D W What is your job? _____

Do you smoke, use tobacco, or vape? Y N How many per day:_____

Do you drink alcohol? Y N How many drinks per day: _____

Do you use street drugs? Y N Last used: _____

Within the last year, have **You** been hit, slapped, kicked, or otherwise physically hurt by anyone? Y N

Within the last year, has anyone forced **You** to have any sexual activities Y N

Since your last visit, has anyone in **Your** family developed any of the following:

Colon Cancer, Breast Cancer, Ovarian Cancer, Heart Disease, Diabetes, Mentall Illness, Bleeding Disorder, Tuberculosis

Are you up to date on your immunizations? Y N

Recommended:

Flu Vaccine Date:_____ Where:_____

T-Dap Date:_____ Where:_____

Pneumonia vaccine: age 65

Shingles vaccine: age 60

AUTHORIZATION for USE and/or CLOSURE of PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information, as set forth below. I understand 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 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's Notice of Privacy Practices. I have had full opportunity to read and consider the contents 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: _____