

## Next Century Medical Care, LLC Patient Registration Form

Patient Information					
Date:	Social Security #:	Provider: Wilbur for Primary Care (Circle One) Estes for Allergy, Asthma, and Immunology			
Last Name:		First Name:		M.I.	
Street Address:		Apt #:	City, State, Zip:		
DOB:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: (Circle One) Single Married Divorced Widowed Separated			
Home Phone #:	Work Phone #:	Cell Phone #:	Email:		
Preferred Method of Contact: (Circle One) Home Work Cell		Accept Texts: <input type="checkbox"/> Yes <input type="checkbox"/> No	Accept Emails: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Emergency Contact Information					
Last Name:		First Name:		Contact #:	
Responsible Party's Information (Bill to) (If patient, please leave blank. If patient is under 18 years old, please complete with parent/guardian's information.)					
Last Name:		First Name:		M.I.:	
DOB:	Social Security #:	Contact #:	Relationship with patient:		
Referral Information					
Referring Source: Internet Search Website Friend Relative Healthcare Provider Employee Phonebook (Circle all that apply) Other:					
Primary Care Provider (PCP):			Referring Healthcare Provider:		
Insurance Information					
Primary Insurance:		Policy #:	Group #:		
Effective Date:		PCP Copay:	Specialist Copay:		
Name of Subscriber:		Social Security #:	DOB:		
Patient's Relationship to Subscriber: (Circle One) Self Spouse Child Other:					
Secondary Insurance:		Policy #:	Group #:		
Effective Date:		PCP Copay:	Specialist Copay:		
Name of Subscriber:		Social Security #:	DOB:		
Patient's Relationship to Subscriber: (Circle One) Self Spouse Child Other:					

I hereby assign all medical and/or surgical benefits to include: Medicare, Medicaid, commercial or any and all other health insurance plans to which I am entitled to: Next Century Medical Care, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment. **I understand that I am financially responsible for all charges whether or not paid by my insurance carrier.** I authorize use of this form for all of my insurance submissions. I authorize release of information to my insurance company. I authorize my healthcare provider(s) to act as my agent in helping me obtain payment from my insurance company. I understand that I am responsible for obtaining any referrals that are needed. I understand that any or all of my medical information may be used for blinded-data research in which none of the data will be linked to my identity. I understand that my medical information may be electronically submitted to any or all of my treating healthcare providers, hospitals and/or healthcare entities.

Signature: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_



1400 Philadelphia Pike  
Suite A4  
Wilmington, DE 19809  
Phone: (302) 375-6746  
Fax: (302) 375-6822

### **Patient Information About Office Practices**

We would like to thank you for choosing Next Century Medical Care, LLC as your partner in your health and wellness. We are committed to working with you to ensure the best medical care.

#### **Patient Rights**

1. To reasonable access to the medical services without regard to race color, national origin, age, sex, disability, or financial status.
2. To receive considerate, respectful, and compassionate care.
3. To be informed about and to participate in decisions regarding your care including the refusal of treatment.
4. To be involved in all aspects of care, and to be allowed to participate in that care.
5. To refuse treatment to the extent permitted by law and to be informed of the medical consequences of your actions.
6. To have clinical and educational information about your treatment in language and terms that you understand.
7. To voice complaints about your care, and to have those complaints reviewed and, when possible, resolved.
8. To information about any research activities that involve your treatment, including benefits and risks, procedures involved, and alternative treatments.
9. To security, privacy, and confidentiality in all patient care areas as you undergo tests or treatments.
10. To know who is responsible for providing your immediate, direct care.
11. To information about the financial aspects of services and alternative choices.
12. To request an itemized statement of billed services.

#### **Patient Responsibilities:**

1. To give complete and accurate information about your condition and care, including the reporting of unexpected changes in your condition.
2. To adhere to the mutually agreed upon plan of care, including keeping follow-up office visits.
3. To report unexpected changes in your condition to your healthcare provider.
4. To bring a current copy of your advance directives to be placed in your medical record, if available.
5. To accept responsibility for refusing treatment.
6. To show consideration for other patients by following all common courtesies pertaining to smoking, noise and general conduct.
7. To accept all financial obligations associated with your care.
8. To be considerate of staff who are caring for you. A mutual spirit of respect and cooperation allows us to serve you best.
9. To advise us of any dissatisfaction you may have regarding your care. There is a patient satisfaction survey under our "Contact Us" link on our website.

## Financial Practices

### ***For our patients with medical insurance benefits:***

We participate with most major medical insurance plans. Our revenue cycle management company, PRMS, will submit claims for any services rendered to a patient who is a member of one of these medical insurance plans. We will assist you in any way we reasonably can help get your claims paid. It is the patient's responsibility to provide all necessary information before leaving the office. If you have a secondary insurance plan, we will automatically file a claim with them as soon as the primary insurance plan has paid. Your medical insurance plan may need you to supply certain information directly. It is your responsibility to comply with their request.

Please bring your insurance card with you to each of your office visits. This will ensure we have the most up to date insurance information for you. However, if you change your medical insurance plan, it is best to notify us immediately so that we can ensure you can be seen with us at your next office visit.

If you are insured by a medical insurance plan we participate with but do not have your insurance card with you, payment in full for each visit is required until we can verify your coverage. If a patient is a member of a medical insurance plan with which we do not participate with, payment in full is due at the time of service. We will submit our charges to your insurance company to collect any out of network benefits that may be available to you, but ultimately the patient is responsible for any unpaid balances.

Accepted medical insurance plans are list on our website [www.NextCenturyMedicalCare.com](http://www.NextCenturyMedicalCare.com) or call our office at (302) 375-6746.

Your medical insurance plan requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. For your convenience we accept cash and credit cards: Visa, Mastercard, and Discover. If you do not have your co-payment, your office visit may be rescheduled. You may also have co-insurance and/or deductible amounts required by your medical insurance plan. Any outstanding balance on your account, after adjusting for all your medical insurance plan responsibilities, will addressed at your office visit.

It is the policy of Next Century Medical Care, LLC to treat all patients in an equitable fashion related to account balances. We do not waive, fail to collect, or discount co-payments, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law, as well as participating agreements with medical insurance plans.

Medical services that are considered by your medical insurance plan to be non-covered, out of network, or not medically necessary will be your responsibility.

### ***For our patients without medical insurance benefits:***

If you do not have group or individual medical insurance plan coverage, payment for all professional services is expected at the time of your office visit. In the setting of financial hardship, we can make payment arrangements on a case by case basis.

### ***Payment plan for patient with and without medical insurance benefits:***

If you are unable to pay your total balance at once, a payment plan option may be available to you. All payment plans are expected to be paid off within twelve months. To set up a payment plan, please call the office at (302) 375-6746.

**Patient Attendance Policies**

***Late Office Visit Arrivals***

A patient who arrives more than 30 minutes for a primary care office visit or 15 minutes for an allergy, asthma and immunology office visit is considered a late arrival. A late arrival, not considered to be the responsibility of the practice, will be registered and worked into the schedule as soon as possible, including rescheduling to another day.

***No Show for Office Visit***

Any patient who fails to arrive for a scheduled office visit without cancelling at least 24 hours prior to the scheduled appointment is considered a “No Show.” A “No Show” patient may be charged \$40.00 fee, as set by the practice for failure to show. A patient who is “No Show” for three office visits may be dismissed from the practice.

**Patient Forms Request Policy**

Based on insurance policies, patients requesting forms to be completed that are not related to patient disease management (i.e. Asthma Action Plan, Food Action Plan, etc.) will be charged a \$20.00 administrative fee per set of forms. The fee will be for each time the form is requested to be completed. Please allow a 1-week turnaround time.

**Prescription Renewal Request Policy**

If you require a prescription renewal in-between routine office visits, please call the office to notify the front desk. They will take your pertinent information and pass along to the healthcare provider who prescribed the medication. Please allow a 72-hour turnaround time for prescription renewals. If a prescription cannot be renewed, you will receive a phone call back stating so.

If you are due for an office visit, you may need to schedule a visit before a renewal can be ordered. If an office visit is not available before running out of the medication and the healthcare provider is legally able to do so, an adjusted prescription renewal may be issued until the date of the scheduled office visit.

By signing below, you indicate that you have read, understand, and accept Next Century Medical Care, LLC’s policies. Please let us know if you have any questions or concerns.

Patient’s printed name: \_\_\_\_\_

Patient’s DOB: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient, Guarantor, or Personal Representative

Date: \_\_\_\_\_



## Authorization to Discuss Protected Health Information

I \_\_\_\_\_ authorize Next Century Medical Care, LLC to release or discuss information related to my medical condition (including information related to my treatment plan, medical information and/or billing information) to the following named persons:

1. Full Name: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_
2. Full Name: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_
3. Full Name: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_
4. Full Name: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

Please be advised that any person not referred to on this list will not be given any information related to your care, including billing information. You may change, restrict, or expand this listing at any time. **You are not required to list any name if you do not so choose.**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone: (302) 375-6746 Fax: (302) 375-6822

NextCenturyMedicalCare@outlook.com

NextCenturyMedicalCare.com

1400 Philadelphia Pike Suite A4

Wilmington, DE 19809





1400 Philadelphia Pike  
Suite A4  
Wilmington, DE 19809  
Phone: (302) 375-6746  
Fax: (302) 375-6822

## HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

This consent was signed by: \_\_\_\_\_  
(PRINT NAME PLEASE)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



# New Allergy, Asthma and Immunology Patient History

Date form completed: \_\_\_\_\_  
 Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Pharmacy Name and Phone Number: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_  
 \_\_\_\_\_

**Drug Allergies for you:** (Attach list if needed.)

Drug Name	Severity (Mild/Moderate/Severe)	Symptoms	Onset (Childhood/Adulthood/Unknown)

**Food Allergies for you:** (Attach list if needed.)

Food	Severity (Mild/Moderate/Severe)	Symptoms	Onset (Childhood/Adulthood/Unknown)

**Environmental Allergies for you:** (Attach list if needed.)

Allergen	Severity (Mild/Moderate/Severe)	Symptoms	Onset (Childhood/Adulthood/Unknown)

**All Drugs you take:** (Attach list if needed.)

Drug Name	Dosage	How often	To treat

Do you have a home nebulizer? Yes/No \_\_\_\_\_ Date when purchased: \_\_\_\_\_

### Smoking History for you:

**Tobacco Use:** Yes/No    Type: \_\_\_\_\_    How much: \_\_\_\_\_    For how long: \_\_\_\_\_

**Secondhand Tobacco Exposure:** Yes/No    Where: \_\_\_\_\_

#### Emergency Room Visits/Hospitalizations for you: (Attach list if needed.)

Date	Reason

#### Surgeries for you: (Attach list if needed.)

Date	Type of surgery

#### Your Medical History and Diagnoses *(Please circle all that apply to you.):*

<b>Eyes</b>	Glasses; contact lenses; cataracts; glaucoma; blindness; Other:
<b>Ears</b>	Hearing aids; chronic ear infections, current ear tubes; h/o ear tubes; Other:
<b>Nose</b>	Nasal polyps; nasal septum perforation; nosebleeds; chronic sinus infections; Other:
<b>Cardiovascular</b>	Abnormal heart rhythm; blood clots; heart disease, heart murmur; high blood pressure; pacemaker; rheumatic fever; stroke; peripheral vascular disease; varicose veins; Other:
<b>Respiratory</b>	Asthma; COPD; chronic bronchitis, cystic fibrosis; emphysema; tuberculosis; pneumonia; pulmonary embolism; sleep apnea; require supplemental oxygen; Other:
<b>Gastrointestinal</b>	Acid reflux; Crohn's Disease; esophagitis; gallbladder disease; hernia; irritable bowel syndrome; polyps; ulcer; ulcerative colitis; Other:
<b>Musculoskeletal</b>	Osteoarthritis; gout; osteoporosis; chronic back pain; joint infections; recurrent sprains; recurrent broken bones; Other:
<b>Integumentary</b>	Acne; hair loss; excessive hair growth; nail disease; rosacea; psoriasis; recurrent cellulitis; Other:
<b>Neurological</b>	Dementia; encephalitis; seizures; migraines; memory loss; h/o head injury; paralysis; tremor; syncope; Parkinson's; multiple sclerosis; Other:
<b>Psychiatric</b>	Anxiety; depression; suicide attempt, bipolar; obsessive compulsive disorder; insomnia; previous or current psychiatrist/psychologist care; Other:
<b>Endocrine/ Rheumatologic</b>	Autoimmune disease; diabetes; fibromyalgia; lupus; kidney/renal disease; Raynaud's; rheumatoid arthritis; scleroderma; thyroid disease; Other:
<b>Hematologic/ Immunologic/ Lymphatic</b>	Anemia; chronic infections; HIV; h/o a blood transfusion; leukemia; lymphedema; multiple myeloma; thrombocytopenia; Other:
<b>Cancer</b>	Breast; brain; lung; pancreatic; ovarian; prostate; stomach; liver; skin; cervical; esophageal; Other:



**Family History** (Please check all that apply to your biological family.):

If adopted, please check here.

	Asthma	Allergies	Eczema	Hereditary Angioedema (Swelling)	Chronic Infections	Other: (list)
Mother	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	
Father	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	
Brother	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	
Sister	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	
Maternal GM	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	
Maternal GF	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	
Paternal GM	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	
Paternal GF	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	

**Preventative Care for you:**

Testing/Care	Date when last performed
Bone density scan	
Eye exam	
Chest x-ray	
Chest CT	

**Social History for you:**

**Occupation:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Marital status:** Single      Married      Divorced      Separated      Widowed

**Number of children:** \_\_\_\_\_

**Environmental History for you:**

**Type of home:** Single family    Townhouse    Mobile home    Apartment    Other: \_\_\_\_\_

**Age of home:** \_\_\_\_\_      **Length of residency:** \_\_\_\_\_

**Heat/cooling system:** Central    Window/Radiators      **Foundation:**    Basement      Crawl space      Slab

**Pillows:**      Feather pillows      Foam pillows      **Bedding:**      Standard      Hypoallergenic

**House plants:** Yes/No    If yes, number and location \_\_\_\_\_

**Any pets:**    Yes/No      If yes, please provide the following information about your pets.

Pets	Number	How long owned	Bathing frequency	Bedroom access	Any allergy symptoms
Cat				Yes/No	Yes/No
Dog				Yes/No	Yes/No
Bird				Yes/No	Yes/No
Other: (specify)				Yes/No	Yes/No

**Symptoms that you are experiencing (Circle all that apply to you.)**

<b>Constitutional</b>	Appetite change Fever	Dietary change Night sweats	Feeling unwell	Unable to complete activities of daily living Unable to exercise		Weight change Unexplained tiredness	
<b>Eyes</b>	Dark circles Flashing lights		Dry Pain	Itchy	Red	Swelling	Watery
<b>Ears</b>	Pain Ringing	Itch Dizziness	Eczema	Fullness	Popping	Discharge	Poor hearing
<b>Nose</b>	Decreased smell Runny nose		Congestion Sinus headaches	Postnasal drip	Sneezing Sinus pain	Recurrent nose bleeds Sinus pressure	
<b>Mouth</b>	Bad breath	Bleeding gums	Dry	Itch	Sore tongue	Tongue swelling	Jaw pain with eating
<b>Neck/Throat</b>	Enlarged thyroid	Hoarseness	Lumps	Soreness	Swallowing problems	Swollen glands	Throat clearing
<b>Cardiovascular</b>	Chest pain/ pressure	Shortness of breath w/ exercise	Shortness of breath w/ at rest	Palpitations	Extremity swelling	Leg cramps	Leg pain with walking
<b>Respiratory</b>	Dry cough Hard to get air into the lungs	Productive cough Hard to get air out of the lungs		Coughing up blood	Chest pain with breathing	Change in sputum/phlegm	Wheezing
<b>Gastrointestinal</b>	Nausea	Vomiting	Diarrhea	Constipation	Black stools	Change in bowel habits	Abdominal pain/cramps
<b>Genitourinary</b>	Urgent urination	Frequent urination	Painful urination	Frequent night urination	Bloody urine	Flank/bladder pain	Frequent bladder infections
<b>Musculo-skeletal</b>	Joint pain	Joint swelling	Joint stiffness	Decreased joint motion	Muscle pain	Muscle loss	
<b>Integumentary</b>	Dry	Itch	Rash	Hair changes	Skin changes	Nail changes	Mole changes
<b>Neurological</b>	Fainting Walking/balance problems	Dizziness	Double vision	Involuntary movement Vision loss	Unusual/new headaches	Sensation change	Weakness
<b>Psychiatric</b>	Sleep habit change	Moody	Anxious	Recurrent bad thoughts	Mood swings	Hallucinations	Compulsions
<b>Endocrine</b>	Abnormal growth	Excessive sweating	Hair changes	Hot/cold intolerance	Thirst change	Urine volume increase	Menstrual irregularity
<b>Hematologic/ Lymphatic</b>	Easy bruising		Easy bleeding			Unexplained swollen areas	
<b>Allergic/ Immunologic</b>	Frequent infections		Excessive swelling		Eczema	Hives	Anaphylaxis

When do you have allergy symptoms: Year round without seasonal symptoms  
 Year round with seasonal symptoms  
 Seasonal only

If seasonal **eye and nose symptoms**, what seasons are worse? Spring Summer Fall Winter

Any known **eye and nose triggers**:

Allergens: \_\_\_\_\_

Irritants: \_\_\_\_\_

Weather-related: \_\_\_\_\_

Work-related: \_\_\_\_\_

If seasonal **respiratory symptoms**, what seasons are worse? Spring Summer Fall Winter

Any known **respiratory triggers**:

Allergens: \_\_\_\_\_

Irritants: \_\_\_\_\_

Weather-related: \_\_\_\_\_

Work-related: \_\_\_\_\_

If seasonal **skin symptoms**, what seasons are worse? Spring Summer Fall Winter

Any known **skin triggers**:

Allergens: \_\_\_\_\_

Irritants: \_\_\_\_\_

Weather-related: \_\_\_\_\_

Work-related: \_\_\_\_\_

**Past Allergy, Asthma, and Immunology History:**

Testing	Date	Results
Environmental allergy skin testing		
Environmental allergy blood testing		
Food allergy skin testing		
Food blood testing		
Treatment	Date started	Date stopped
Allergy shots		

**Immunizations:**

Immunization	Date when last administered
Flu (Influenza)	
Pneumonia (Pnemovax 23)	
Pneumonia (Prenvar 13)	
Tetanus Diphtheria (Td/Tdap)	
Shingles (Zostavax/Shingrix)	

Do you have allergy symptoms when you are stung by insects, such as bees? Yes/No

If yes, symptoms: \_\_\_\_\_

Do you have allergy symptoms when exposed to latex products: Yes/No

If yes, symptoms: \_\_\_\_\_