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:** ☐ M ☐ 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**: ☐ Yes ☐ No	**Accept Emails:** ☐ Yes ☐ No	
Do you authorize Next Century Medical Care to retrieve your prescription history for your care? ☐ Yes ☐ 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 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 state issued identification card and 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.

Call our office to verify if we accept your medical insurance plan. 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.

Appointment Confirmation and Patient Attendance Policies

Appointment Confirmation

It is very important to confirm your appointment when the appointment confirmation system contacts you. We only have so many appointments per day and cannot continually "waste" appointments when patients "No Show." ***If you do not confirm your appointment, your appointment will be cancelled.*** We will reschedule unconfirmed appointments with patients that need the appointment.

Late Office Visit Arrivals

A patient who arrives more than 15 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. An established patient who is "No Show" for three office visits may be dismissed from the practice. New patients that "No Show" for the first appointment will not be seen and cannot reschedule.

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: _____

Next Century
MEDICAL CARE LLC • By Nurse Practitioners

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

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Suite A4
Wilmington, DE 19809
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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.)*:

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

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