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: _____

Next Century
MEDICAL CARE LLC • By Nurse Practitioners

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: _____

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name _____

Age _____

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product _____			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of a COVID-19 vaccine including either of the following:			
○ Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.			
• A previous dose of COVID-19 vaccine.			
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			
12. Do you have dermal fillers?			

Form reviewed by _____ **Date** _____

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COVID-19 Vaccination Consent Form

1. I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 18 years of age; or (c) legally authorized to consent for vaccination for the patient named below.
2. I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in specified individuals (18 years of age or older for the Moderna or the Johnson & Johnson vaccines; 16 years of age or older for Pfizer vaccine); and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.
3. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s).
4. I understand the risks and benefits associated with the above vaccine and have received the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive.
5. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
6. I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes for patients without anaphylaxis history and 30 minutes for patients with anaphylaxis history after administration. If I experience a severe reaction I leave, I will call 9-1-1 or go to the nearest hospital.
7. I acknowledge that Delaware Immunization Registry (DelVax) and Delaware Health and Social Services (DHSS) will record my personal immunization information and will share with the Centers for Disease Control (CDC) or other federal agencies.
8. I further authorize the submission of a claim to my insurance provider for the vaccine administration.

Patient signature:_____ Date:_____

Printed patient name:_____

Patient DOB:_____

Relationship to patient, if other:_____

3.10.21