The Pearl Clinic
pearlclinicllc.com

230 Mitchell Street, Suite B
Millsboro, DE 19966
(p)302-648-2099  (F)302-648-2097

# Welcome to Our Practice

As a new patient we would like to welcome you to our practice! We look forward to taking care of your healthcare needs. Addressing the needs of each patient as a personalized approach is a priority in our practice. We ask that you arrive 30 minutes prior to your scheduled appointment time.

Along with this letter you will find all the necessary paperwork for your appointment with us. Kindly complete these forms and bring them with you to your appointment along with your insurance card and photo identification.

***Most importantly, enclosed is an Authorization to Receive Medical Records/Information form. Please fill this out and give it to your prior family physician's office so that they can send us your medical records prior to your appointment.***

If you have any questions or concerns before your scheduled appointment, please feel free to contact us.

Sincerely,

The Pearl Clinic

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# AUTHORIZATION TO RECEIVE MEDICAL RECORDS/INFORMATION

I authorize the release of my medical records by the organization or physician listed below:

Physician's Name: _____

Physician's Address: _____

Physician's Phone #: _____Fax#: _____

Reason for Records Release: _____

**These records are to be faxed to the Pearl Clinic, LLC @ 302-648-2097**

Patient's Name: _____Date of Birth: _____

Address: _____State:_____Zip Code:_____

Social Security#: _____-_____-_____ Phone #:_____

The type of information to be disclosed is initialed as follows: (specify dates where appropriate).

____Entire Medical Record ____ Substance & Drug Abuse ____Immunizations

____Most recent 3 years of records ____Dermatology Records ____Sleep Studies

____AIDS/HIV, if any ____Psychological or Psychiatric, conditions, if any

Other:_____

I understand this authorization will expire, without my revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to the state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization to my insurance company. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Patient Signature Today's Date

_____ _____
Patient's Parent/Guardian/Representative Relationship to patient

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# PATIENT REGISTRATION FORM

Last Name _____ MI _____ First Name_____

Home Address _____
Street Address

_____
City State Zip

Mailing Address _____
Street Address

_____
City State Zip

Date of Birth _____ Social Security # _____--_____--_____

Home Phone _____Work Phone _____Cell Phone _____

Email Address_____

**Person to contact in case of an emergency:** (Relative or friend that does not live with you)

Name _____Telephone #_____

Relationship to patient _____

Primary Language: _____Do you need an interpreter _____YES _____NO

Local Pharmacy:_____

Mail Order Pharmacy_____

Primary Laboratory for blood work: _____ Primary Imaging Facility: _____

| | |
|---|---|
| **Gender:**<br>Male<br>Female<br>Transgender | **Are you:**<br>Hispanic/Latino<br>Not Hispanic/Latino<br>Decline |
| **Marital Status:**<br>Single<br>Married<br>Divorced<br>Separated<br>Widowed<br>Life Partner<br>Other _____ | **Race:**<br>White<br>Black/African American<br>Asian<br>American Indian/Alaskan Native<br>Native Hawaiian/Pacific Islander<br>Multiracial<br>Other: _____<br>Decline |

**Insurance Information:**

Primary Insurance Company Name: _____

Policy Holder's Name:_____ Policy Holder's DOB: _____

Policy Member ID/Policy Number: _____ Group Name/Number: _____

Relationship to Policy Holder: _____

Secondary Insurance Company Name: _____

Policy Holder's Name:_____ Policy Holder's DOB: _____

Policy Member ID/Policy Number: _____ Group Name/Number: _____

Relationship to Policy Holder: _____

Tertiary Insurance Company Name: _____

Policy Holder's Name:_____ Policy Holder's DOB: _____

Policy Member ID/Policy Number: _____ Group Name/Number: _____

Relationship to Policy Holder: _____

# AUTHORIZATION AND CONSENT FORM

I request care from The Pearl Clinic, LLC for treatment of my medical conditions. This may include medical tests, exams and any other treatments that are needed for me, I agree to this care.

**Insurance and Payments:**

The Pearl Clinic LLC receives payment for patient care from insurance companies. Medicare and /or other third party programs.

I agree to have my insurance company, Medicare, or other third party payment programs, make payments directly to The Pearl Clinic, LLC.

I request that payment of authorized medicare benefits be made either to me or on my behalf to The Pearl Clinic, LLC for any services furnished to me by a physician or supplier. I authorize any holder of medical financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand that I must pay all charges, co-payments and deductibles that are not covered by my insurance company, Medicare or third party payment programs.

**If your insurance requires authorization or referral, you are responsible for providing it at the time of your visit or you will be responsible for these charges.

All self pay patients are required to pay the full amount of the visit charges at the time of the office visit.

At the time of visit, you are required to provide a copy of your photo ID and active insurance card(s).

It is the patient's responsibility to inform us if a specific lab needs to be used. The Pearl Clinic, LLC is NOT responsible if your insurance requires a specific lab.

_____ _____

**Signature of the patient** (or person authorized to sign for patient): **Date:**

_____

**Relationship to patient**

**Office Policy and Service Agreement:**

***It is our office policy that if three (**3**) office appointments are missed without 24 hours notice, you will be dismissed from the practice for non-compliance.

For any disability forms that needs to be completed by the provider, an office visit will need to be made for this service. All the patient information on the forms must be completed prior to giving the form to the provider.

If for any reason a personal check is returned from our bank, you will be required to pay cash for the returned check along with a $30.00 bank charge. Failure to rectify this will result in the Accounts Receivable Department sending this to the State of Delaware Check Enforcement Program.

When you call the office for a prescription refill or a new prescription, please be aware that it may take up to 72 hours for it to be completed.

Tint Waivers. Effective January 1, 2020 The Pearl Clinic, LLC will no longer be filling out tint waiver forms without a written recommendation and clinical diagnosis of migraines by a Neurologist. Tint waivers will no longer be signed for history of migraines or photophobia diagnosis.

_____ _____

**Signature of the patient** (or authorized person to sign for patient): **Date:**

_____

**Relationship to patient**

**Missed Appointment Policy:**

Due to our commitment to meeting our patient's needs, your appointment is time set aside specifically for you. When your appointment is missed, it prevents us from being able to help another patient. Please cancel your appointment at least 24 hours prior to your scheduled appointment time so we may be able to help another patient. Any appointments missed without 24 hours notice or more, will result in a $25.00 no show fee. It is understandable that some situations may prevent you from keeping an appointment and your no show fee may be waived. Insurance does not cover no show fees. After 3 missed appointments, you will be dismissed from the practice.

I have read this document and understand that I will be financially responsible for all missed scheduled appointments that are not canceled as described in the policy above.

_____ _____

**Signature of the patient** (or person authorized to sign for patient): **Date:**

_____

**Relationship to patient**

# MEDICAL INFORMATION RELEASE FORM (HIPAA FORM)

Name: _____ Date of Birth ____/____/____

## RELEASE OF INFORMATION

_____ I authorize the release of information including diagnosis, records, examination rendered to me and claims information. This information may be released to (complete all that apply):

_____ SPOUSE/SIGNIFICANT OTHER_____

_____ CHILDREN _____

_____ OTHER_____

_____ DO NOT release my information to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

## MESSAGES

Please call: ___ My Home ___My Work ___My Cell Phone

If unable to reach me:

___You may leave a detailed message.

___Please leave a message asking me to return the call ONLY.

___Other _____

The best time of day to contact me is: _____

_____ _____

**Signature of the patient** (or person authorized to sign for patient): **Date:**

_____

**Relationship to patient**

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# PATIENT MEDICAL INFORMATION SHEET

FIRST NAME:_____LAST NAME:_____ DOB: _____

**CARE TEAM:**
List ALL other medical providers names and specialties you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

_____

_____

_____

**ALLERGIES-FOOD/MEDICATIONS**:_____or___**NKDA**_____

**List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.**

_____

_____

_____

**VACCINE HISTORY:**

| | | |
|---|---|---|
| COVID VACCINE | YES / NO | DATE(S):_____ |
| FLU VACCINE | YES / NO | DATE(S):_____ |
| PNEUMONIA VACCINE | YES / NO | DATE(S):_____ |
| TETANUS VACCINE | YES / NO | DATE(S):_____ |
| SHINGLES VACCINE | YES / NO | DATE(S):_____ |

**PERSONAL MEDICAL HISTORY:** (*Please circle all that apply)*

| | | | | |
|---|---|---|---|---|
| ADHD | COPD | Emphysema | High Cholesterol | Rheumatoid Arthritis |
| Alcoholism | Dementia | HIV | Seizure Disorder | Allergies, |
| Depression | Hepatitis | Sleep Apnea | Anemia | Diabetes: 1 or 2 |
| IBS | Stroke | Anxiety | Diverticulitis | Lupus |
| Arrhythmia | DVT | Liver Disease | Ulcerative Colitis | Thyroid Disease |
| Arthritis | Acid Reflux | Glaucoma | Asthma | Macular Degeneration |
| Neuropathy | Bipolar | Heart Disease | Hiatal Hernia | Osteopenia/Osteoporosis |
| Incontinence | Heart Attack | Parkinson's Disease | Bleeding Problems | Bladder Problems |
| Peripheral Vascular Disease | | High Blood Pressure | Pulmonary Embolism (PE) | |
| Peptic Ulcer | Headaches | Kidney Stones | Psoriasis | Crohn's Disease |
| Kidney Disease | | | Cancer: _____ | |

Last Menstrual Period Date: _____ Colonoscopy Yes/No Date:_____

Mammogram Yes/No Date:_____ Bone Density Study Yes/No Date:_____

Pap Smear Yes/No Date:_____ Other medical problems not listed_____

**FAMILY HISTORY:**

Please tell us who has had the following medical conditions in your family. Use M-Mother, F-Father, G-Grandparents or S-Sibling.

| | |
|---|---|
| **-Arthritis _____** | **-Heart Attack_____** |
| **-Asthma _____** | **-Hyper or Hypothyroidism _____** |
| **-Diabetes _____** | **-Kidney Disease _____** |
| **-Gout _____** | **-High Cholesterol _____** |
| **-Depression _____** | **-Anxiety _____** |
| **-Stroke _____** | **-COPD _____** |
| **-Sleep Apnea _____** | **-Anemia _____** |
| **-Heart Disease _____** | **-High Blood Pressure _____** |
| **-Other _____** | **-Cancer_____** |

**SOCIAL HISTORY:**

**Smoking/ Tobacco Use:**

**Circle One**

☐ Current ☐ Past ☐ Never Cigarette/Cigar/Pipe/Chewing Tobacco

(Please complete if current or past smoker) Amount/day: _____ Number of Years: _____

Occupation:_____ Employed: ☐ yes ☐ No

Are you able to take care of yourself? ☐Yes ☐ No

Exercise Level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

General Stress Level: ☐ Low ☐ Medium ☐ High

Diet: ☐ Regular ☐ Vegetarian ☐ Vegan ☐ Gluten Free ☐ Other_____

Caffeine Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Alcohol Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Illicit or Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type:_____

Do you have an Advanced Directive? ☐Yes ☐ No Do you have a Living Will: ☐Yes ☐ No

**SURGICAL HISTORY:**

**Please list all prior surgeries and approximate dates performed.**

_____

_____

_____

Patient Signature: _____ Date: _____