PEARL CLINIC

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.

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. **Please plan to arrive 30 minutes prior to your scheduled appointment time**. If you are late, you may be asked to reschedule.

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: _____Transferring Primary Care_____

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

__X__ Most recent 3 years of records ____ Dermatology Records __X__ Labs and Imaging

____ AIDS/HIV _____ Psychological or Psychiatric 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/Legal Guardian Signature Today's Date

_____ _____

Relationship to Patient Today's Date

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PATIENT REGISTRATION FORM

First Name: _____ MI: _____ Last Name: _____

Physical Street Address: _____ Mailing Address: _____

City, State, Zip: _____ City State Zip: _____

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

Home Phone: _____ Work Phone: _____ Cell: _____

Gender: _____ Relationship Status: _____ Race: _____

Ethnicity: Hispanic/Latino or Not Hispanic/Latino (circle one) Email: _____

Primary Language: _____ Do you need an interpreter? ____ YES ____ NO

Person to contact in case of an emergency:

Name: _____ Telephone#: _____

Relationship to patient: _____

Local Pharmacy: _____ City: _____

Mail Order Pharmacy: _____

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

Insurance Information:

Primary Insurance Company Name: _____
Policy Member ID/Policy Number: _____ Group Name/Number: _____
Policy Holder's Name:_____ Policy Holder's DOB: _____
Relationship to Policy Holder: _____

Secondary Insurance Company Name: _____
Policy Member ID/Policy Number: _____ Group Name/Number: _____
Policy Holder's Name:_____ Policy Holder's DOB: _____
Relationship to Policy Holder: _____

(If you have a tertiary insurance, please let the front desk know this at check in)

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INSURANCE AND OFFICE POLICIES

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

**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.

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.

Office Policies and Service Agreement: 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.

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 photo phobia diagnosis.

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 $50.00 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 for non-compliance.**

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Signature Required

By signing below, you have acknowledged that you have read and agreed to all of the above office and insurance policies.

_____ _____

Patient Signature (or Legal Guardian) **Date**

_____

Relationship to patient

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MEDICAL INFORMATION RELEASE FORM (HIPAA FORM)

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

_____ SPOUSE/SIGNIFICANT OTHER _____

_____ CHILD(REN)_____

_____OTHER _____

_____ **DO NOT** release my information to anyone.

MESSAGES

Best Time of Day to Contact you? _____

Best Source of Contact?

____ My Home ____ My Work ____ My Cell Phone

If we are unable to reach you, are we able to leave a detailed voicemail? ____YES ____NO

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PATIENT MEDICAL INFORMATION SHEET

CARE TEAM:

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

_____

_____

_____

ALLERGIES-FOOD/MEDICATIONS: _____

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.

THIS IS VERY IMPORTANT _____

_____

_____

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): _____

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

Anxiety/Depression/ADHD/Bipolar		Arrhythmia	Arthritis	Acid Reflux
Anemia	COPD/Asthma	Dementia	Seizure Disorder	Incontinence
Diabetes	Heart Attack	Hypothyroidism	High Blood Pressure	Migraines
History of DVT	High Cholesterol	Hepatitis	History of Pulmonary Embolism	
Kidney Disease	Kidney Stones	Nephropathy	Parkinson's	
History of Stroke	Sleep Apnea	Vascular Disease	Substance Abuse Disorder	

Cancer (what kind) _____

Women:
Last Menstrual Period: _____
Last Mammogram: _____
Last Pap Smear: _____
Last Bone Density: _____

Men:
Last PSA draw: _____

Have you had a colonoscopy in the past? _____ If so, When? _____

Have you had a Cologaurd Test done? _____ If so, When?_____

FAMILY HISTORY

(Please tell us who has had the following medical conditions in your family.)

Use M-Mother, F-Father, B-Brother or S-Sister

____ Anxiety/Depression ____ Dementia ____ Diabetes ____ Heart Attack

____ High Blood Pressure ____ High Cholesterol ____ History of Stroke

____ Parkinson's ____ Sleep Apnea

____ Cancer-Please list **who** and **what kind** of cancer they had.

_____

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SOCIAL HISTORY

Substance Use:

Do you smoke or have you ever smoked?_____ If a **former smoker**, what year did you quit? _____

How much do/did you smoke a day? _____ What age did you start? _____

Do you drink alcohol? _____ If so, how often do you have a drink? _____

Do you smoke marijuana or use any recreational drugs? _____

Do you drink caffeinated beverages? ____ If so, please list them? _____

Advanced Directive:

Do you have an Advanced Directive?_____ Do you have a Living Will? _____

Do you have a medical power of attorney?_____ Name & Relationship_____

Occupation:

Are you employed? _____ Yes?, What is your occupation? _____

Diet and Exercise:

What type of diet do you follow? Regular/Vegetarian/Vegan/Specific (what kind)_____

What is your exercise level? None/Occasional/Moderate/Heavy How many times a week? _____

Activities of Daily Living:

Are you able to care for yourself? _____ Do you walk with any assisted devices? _____Type?_____

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SURGICAL HISTORY

Please list all prior surgeries and approximate dates performed.

_____

_____

_____