The Pearl Clinic
pearlclinicllc.com
230 Mitchell St. Suite B Millsboro, DE 19966
[p] 302-648-2099 [f] 302-648-2097

PATIENT REGISTRATION FORM

(Please print clearly)

Last Name _____ MI _____ First Name _____

Date of Birth _____

Home Address _____

Street *City* *State* *Zip*

Mailing Address if different _____

Street *City* *State* *Zip*

Home Phone _____ Work Phone _____ Other/Cell Phone _____

Gender:	**Are You:**
• Male • Female	• Hispanic/Latino • Not Hispanic/Latino
Marital Status:	**Race:**
• Single • Married • Divorced • Separated • Widowed • Life Partner • Other:_____	• White • Black/African American • Asian • American Indian/Alaskan Native • Native Hawaiian • Pacific Islander • Multiracial • Other:_____

Responsible person: (if different from patient)

Last Name _____ MI _____ First Name _____

Date of Birth _____ Telephone # _____

Address _____

Relationship to patient _____

Primary Language:_____ Do you need an interpreter? □ Yes □ No

Person to contact in case of emergency:

Name _____ Telephone # _____

Relationship to patient _____

Name:_____ Date:_____

Medications:

Name	Dose	Frequency

Allergies & Reaction: _____

_____

Local Pharmacy:_____
Mail Order Pharmacy:_____

Family History: Has any blood relative ever had?

☐ Heart attack before age 55 ☐ Alzheimer's/Dementia ☐ High Blood Pressure

☐ Diabetes ☐ Depression/Anxiety ☐ High Cholesterol

☐ Stroke ☐ Asthma/Allergies ☐ Cancer: Type_____

Social History:

Tobacco Use:

☐ Never

☐ Former

Date Quit _____

☐ Current

Smoke ___packs/day for ___Years

Alcohol Use:

☐ I do not drink

☐ I drink ____ drinks/week

Recreational Drug Use:

☐ Never

☐ Formerly used:_____

☐ Currently use:_____

Do you have Advance Healthcare Directives or a Living Will? **YES / NO**

New Patient Questionnaire for The Pearl Clinic

Name: _____ DOB: _____ Date: _____

Are you here for: ☐ Primary Care ☐ Sleep Medicine ☐ Nutrition

Your Current primary care provider: _____

Do you see any specialists?

☐Cardiology ☐Pulmonology ☐ Endocrinology ☐ Dermatology

☐Neurology ☐Orthopedics ☐ Psychiatry ☐ Gastroenterology

☐Others: _____

Medical History:

Check all that apply:

☐ COPD/Asthma ☐ High Blood Pressure ☐ Kidney Disease

☐ Heart Disease/MI ☐ Diabetes ☐ Reflux/Ulcers of Stomach

☐ CABG/stents ☐ Depression/Anxiety ☐ Enlarged Prostate

☐ Stroke/TIA ☐ Thyroid Disease ☐ Cancer: _____

☐Additional: _____

_____

Surgical History:

Year Surgery

_____ _____

_____ _____

_____ _____

_____ _____

Health Screenings and Immunizations:

Screenings	Y/N	Date	Immunizations	Y/N	Date
Colonoscopy			Flu		
Mammogram			Pneumovax 23		
PAP/GYN			Prevnar 13		
Prostate/PSA			Tdap		
Bone Density			Shingles		
Eye Exam			Hepatitis A/B		

Authorization and Consent

1. I request care from The Pearl Clinic 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 Payment Information:

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

1. I agree to have my insurance company, Medicare, or other third party payment program make payments directly to The Pearl Clinic, LLC.
2. 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.
3. 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 program.
4. If your insurance requires authorization/Referral, you must have it at the time of your visit or you will be responsible for the charge.
5. All self pay patients are required to pay the full amount of the day's charge at the time of the office visit.
6. At the time of your visit, you are required to present an active insurance card and photo ID.
7. 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 as specific lab to be used.

Signature of the patient (or person authorized to sign for patient) _____

Relationship to Patient _____ Date _____

_____

Authorized Staff Signature **Date**

Office Policy and Service Agreement:

1. It is our office policy, that if 3 office appointments are missed without giving proper notification, you will be dismissed from the practice for non-compliance.

2. For any disability form that needs to be completed by the provider, there is a 10.00 charge per form. This fee is required to be paid prior to completion. Please allow 72 hours for the form to be completed. The completed forms must be picked up in the office. All the patient information on the forms must be completed prior to giving the form top the provider.

3. If for any reason a personal check is returned from the 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.

4. 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.

Signature of the patient (or person authorized to sign for patient)_____

Relationship to Patient_____ Date _____

Missed Appointment Policy:

Due to our commitment to meeting our patients' 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 appointments at least 24 hours before the scheduled time so that we may be able to help another patient. It is understandable that some situations may prevent you from keeping an appointment so the fee for the first occurrence will be waived. Any subsequent missed or canceled appointments less than 24 hours prior, will result in a 25.00 fee charged to the patient. Insurance does not cover missed appointment fees.

I have received a copy of 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)_____

Relationship to Patient_____ Date_____

Thank You for your continued support of our practice and we appreciate your cooperation with this policy.

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released 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 Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/____

Witness:_____ Date: ___/____/_____

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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 # of Physician:_____

Reason for Records Release:_____

These records are to be sent to The Pearl Clinic, LLC at the address listed above.

Patient's Name:_____Date Of Birth:_____

Address:_____State:_____Zip Code:_____

Social Security #:_____Phone #:_____

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

_____Entire Medical Record

_____Most recent 3 years of Records

_____Immunizations

_____Dermatology Records

_____Substance and Drug Abuse

_____AIDS/HIV, if any

_____Psychological or Psychiatric conditions, if any

_____Sleep Studies

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 or tom 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.

_____ _____

Patients Name **Today's Date**

_____ _____

Patient's Parent/Guardian/Representative **Relationship to Patient**