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
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        ___ Subst ance & 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
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: ____________________________ Imaging Facility: ____________________________

Page 1

Revised 5.3.21
**Gender:**
- Male
- Female
- Transgender

**Are you:**
- Hispanic/Latino
- Not Hispanic/Latino
- Decline

**Marital Status:**
- Single
- Married
- Divorced
- Separated
- Widowed
- Life Partner
- Other __________

**Race:**
- White
- Black/African American
- Asian
- American Indian/Alaskan Native
- Native Hawaiian/Pacific Islander
- Multiracial
- Other: __________
- 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:

Revised 5.3.21
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

Page 5 Revised 5.3.21
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)*

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD</td>
<td>COPD</td>
<td>Emphysema</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>Dementia</td>
<td>HIV</td>
</tr>
<tr>
<td>Depression</td>
<td>Hepatitis</td>
<td>Sleep Apnea</td>
</tr>
<tr>
<td>IBS</td>
<td>Stroke</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Arrhythmia</td>
<td>DVT</td>
<td>Liver Disease</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Acid Reflux</td>
<td>Glaucoma</td>
</tr>
<tr>
<td>Neuropathy</td>
<td>Bipolar Heart Disease</td>
<td></td>
</tr>
<tr>
<td>Incontinence</td>
<td>Heart Attack</td>
<td>Parkinson’s Disease</td>
</tr>
<tr>
<td>Peripheral Vascular Disease</td>
<td>High Blood Pressure</td>
<td>Pulmonary Embolism (PE)</td>
</tr>
<tr>
<td>Peptic Ulcer</td>
<td>Headaches</td>
<td>Kidney Stones</td>
</tr>
<tr>
<td>Kidney Disease</td>
<td>Cancer: ___________</td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>Heart Attack</td>
</tr>
<tr>
<td>Asthma</td>
<td>Hyper or Hypothyroidism</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Kidney Disease</td>
</tr>
<tr>
<td>Gout</td>
<td>High Cholesterol</td>
</tr>
<tr>
<td>Depression</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Stroke</td>
<td>COPD</td>
</tr>
<tr>
<td>Sleep Apnea</td>
<td>Anemia</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>High Blood Pressure</td>
</tr>
<tr>
<td>Other</td>
<td>Cancer</td>
</tr>
</tbody>
</table>
SOCIAL HISTORY:

Smoking/ Tobacco Use:
☐ Current  ☐ Past  ☐ Never  Circle One  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: ____________