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 ____ Substance & Drug Abuse ____Immunizations

____Most recent 3 years of records ____Dermatology Records ____Sleep Studies

____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

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)

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)

Revised 4.7.22

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 $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 for non-compliance.**

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

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

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.

____

____

____

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)*

Anxiety/Depression/ADHD/Bipolar   Arrhythmia   Arthritis   Acid Reflux

Anemia   COPD/Asthma   Dementia   Disorder of Gastrointestinal Tract

Diabetes   Heart Attack   Hypothyroidism   High Blood Pressure

History of DVT/Pulmonary Embolism   High Cholesterol   Hepatitis   Incontinence

Kidney Disease   Kidney Stones   Nephropathy   Parkinson"s   Migraines

History of Stroke   Sleep Apnea   Substance Abuse Disorder

Seizure Disorder   Vascular Disease   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.

____

SOCIAL HISTORY

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? _____What kind?___________

Are you employed? _________ What is your occupation? __________________________________

Substance Use:

Do you or have you ever smoked? _________ If a former smoker, when did you quit? ___________

If a current smoker, how much do 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_______________________

SURGICAL HISTORY

Please list all prior surgeries and approximate dates performed.

____

____

____

Berlin Questionnaire©

Sleep Apnea

Height (in) ______ Weight (lbs) ______ Age ______ Male/Female

Please choose the correct response to each question.

Category 1

1. Do you snore?
□ a. Yes
□ b. No
□ c. Don’t know

If you answered ‘yes’:

2. You snoring is:
□ a. Slightly louder than breathing
□ b. As loud as talking
□ c. Louder than talking

3. How often do you snore?
□ a. Almost every day
□ b. 3-4 times per week
□ c. 1-2 times per week
□ d. 1-2 times per month
□ e. Rarely or never

4. Has your snoring ever bothered other people?
□ a. Yes
□ b. No
□ c. Don’t know

5. Has anyone noticed that you stop breathing during your sleep?
□ a. Almost every day
□ b. 3-4 times per week
□ c. 1-2 times per week
□ d. 1-2 times per month
□ □ e. Rarely or never

Category 2

6. How often do you feel tired or
fatigued after your sleep?

□ a. Almost every day

□ b. 3-4 times per week

□ c. 1-2 times per week

□ d. 1-2 times per month

□ e. Rarely or never

7. During your waking time, do you feel tired, fatigued or not up to
par?

□ a. Almost every day

□ b. 3-4 times per week

□ c. 1-2 times per week

□ d. 1-2 times per month

□ e. Rarely or never

8. Have you ever nodded off or fallen asleep while driving a vehicle?

□ a. Yes

□ b. No

If you answered 'yes':

9. How often does this occur?

□ a. Almost every day

□ b. 3-4 times per week

□ c. 1-2 times per week

□ d. 1-2 times per month

□ e. Rarely or never

Category 3

10. Do you have high blood
pressure?

□ Yes

□ No

□ Don't know