PEARL CLINIC

28539 DuPont Blvd. 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 Staff

Revised 4.18.2023

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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: _____

Street Address: _____

City: _____ 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: _____

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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 (or Legal Guardian) Today's Date

_____ _____

Relationship to Patient Today's Date

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Patient Registration Form

First Name: _____ MI: _____ Last Name: _____

Primary Address

Street Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address **(*If different from Primary Address*)

Street Address: _____

City: _____ State: _____ Zip Code: _____

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

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Gender: _____ Relationship Status: _____

Race: _____

Ethnicity *(circle one)*: Hispanic/Latino (or) Not Hispanic/Latino

Primary Language: _____

Do you require an interpreter? _____ YES _____ NO

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Emergency Contact Information

Person to contact in case of an emergency:

Full Name: _____

Home Phone: _____ Cell Phone: _____

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: _____ DOB: _____

Relationship to Policy Holder: _____

Secondary Insurance Company Name: _____

Policy Member ID/Policy Number: _____

Group Name/Number: _____

Policy Holder's Name: _____ 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.

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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.

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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) Today's Date

_____ _____

Relationship to Patient Today's Date

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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/SIGNIFICANTOTHER _____

_____ 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.

_____

_____

_____

_____

_____

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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 Migraines Nephropathy Parkinson's

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 Cologuard Test done? _____ If so, When? _____

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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 write 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? _____

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Substance Use:

Do you or have you ever smoked? _____

If you are a former smoker, when did you quit? _____

If you are a current smoker, how much do you smoke a day? _____

What age did you start smoking? _____

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

Do you smoke marijuana or use any recreational drugs? *(add all that apply)*

_____

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

Advanced Directive:

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

SURGICAL HISTORY

Please list all prior surgeries and approximate dates performed.

_____

_____

_____

_____

_____

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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' to #1:

2. Your 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

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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

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

□ a. Yes

□ b. No

If you answered 'yes' to #8:

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