# 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 Sleep Medicine 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. Please complete these forms ENTIRELY and return them to our office. Once we have received your paperwork, we will call you to schedule your new patient appointment. Please arrive 15 minutes prior to your scheduled appointment time.

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: _________ Establishing Sleep 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).

__X__ Last 3 sleep related office notes    __X__ Sleep Studies

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

Revised 10.23.24

# 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: _________________________ Supply Company: _________________________

Local Pharmacy and Pharmacy Phone Number:_____________________________________________

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)**

# 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 $100.00 no show fee for new sleep appointments and a $50.00 no show fee for follow up appointments. 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.**

## 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

Revised 10.23.24

**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.)

Primary Care Provider:______________________________ Supply Company: _________________________

______________________________________________________________________________

______________________________________________________________________________

**ALLERGIES-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): ________________________________

## 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 ever had a Colo-guard 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

**Substance Use:**

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

How much do you smoke(d) a day? _________ What age did you start? _______ How many years? _________

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?___________

# SURGICAL HISTORY

**Please list all prior surgeries and approximate dates performed.**

________________________________________________________________

________________________________________________________________

________________________________________________________________