



**PETER PEARLMAN, M.D.**

BOARD CERTIFIED – OPHTHALMOLOGY

**Phone: (561) 495-0808 • Fax: (561) 499-1704**

5258 LINTON BLVD., #204 • DELRAY BEACH, FL 33484

**PATIENT INFORMATION**

Date: \_\_\_\_\_ Referred By:  Physician  Patient  Other: \_\_\_\_\_

Name: \_\_\_\_\_

*Last*

*First*

*M.I.*

ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ BUSINESS PHONE: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ DRIV.LIC.NO./STATE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_  MALE  FEMALE

MARRIED  SINGLE  OTHER: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

SPOUSE: \_\_\_\_\_ SPOUSE EMPLOYED BY: \_\_\_\_\_

INSURED PARTY INFORMATION (IF OTHER THAN PATIENT):

NAME: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_

PHYSICIAN'S ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

**INSURANCE INFORMATION**

MEDICARE NO: \_\_\_\_\_ STATE: \_\_\_\_\_

PRIVATE COMPANY: \_\_\_\_\_ POLICY # \_\_\_\_\_

SUPPLEMENTAL COMPANY: \_\_\_\_\_ POLICY # \_\_\_\_\_

**\*\* CONTINUED ON THE NEXT PAGE, PLEASE READ AND SIGN \*\***

## PATIENT EYE HISTORY

DATE OF LAST EXAM: \_\_\_\_\_ HOW OLD ARE YOUR GLASSES? \_\_\_\_\_  
PREVIOUS EYE INJURIES:  NO  YES **EXPLAIN:** \_\_\_\_\_  
PREVIOUS EYE SURGEY:  NO  YES \_\_\_\_\_  
RETINAL DETACHMENT:  NO  YES \_\_\_\_\_  
GLAUCOMA:  NO  YES \_\_\_\_\_  
CATARACTS:  NO  YES \_\_\_\_\_  
MACULA DEGENERATION:  NO  YES \_\_\_\_\_

## MEDICAL HISTORY

ARE YOU H.I.V. POSITIVE?  NO  YES  
LIST OF EYE MEDICATIONS: \_\_\_\_\_  
LIST OF OTHER MEDICATIONS: \_\_\_\_\_  
LIST ALL ALLERGIES TO MEDICATIONS: \_\_\_\_\_  
HIGH BLOOD PRESSURE:  NO  YES **EXPLAIN:** \_\_\_\_\_  
HEART DISEASE:  NO  YES \_\_\_\_\_  
LUNG DISEASE:  NO  YES \_\_\_\_\_  
DIABETES:  NO  YES \_\_\_\_\_  
CANCER:  NO  YES \_\_\_\_\_  
OTHER:  NO  YES \_\_\_\_\_  
DO YOU HAVE A HISTORY OF HEPATITIS?  NO  YES \_\_\_\_\_

## FAMILY EYE HISTORY

GLAUCOMA:  NO  YES **FAMILY MEMBER:** \_\_\_\_\_  
CATARACTS:  NO  YES \_\_\_\_\_  
RETINAL DETACHMENT:  NO  YES \_\_\_\_\_  
MACULA DEGENERATION:  NO  YES \_\_\_\_\_  
DIABETES:  NO  YES \_\_\_\_\_  
OTHER:  NO  YES \_\_\_\_\_

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT, NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE BOOKKEEPER.

SHOULD THIS BECOME A COLLECTION PROBLEM, THE PATIENT ASSUMES ALL COSTS OF COLLECTION, INCLUDING BUT NOT LIMITED TO COURT COSTS, INTEREST AND LEGAL FEES.

## **INSURANCE AUTHORIZATION AND ASSIGNED**

Name of Policy Holder \_\_\_\_\_ Number \_\_\_\_\_

I request that payment of authorized Medicare/Other Insurance Company benefits be made either to me or on my behalf to Peter M. Pearlman, M.D., for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or other insurance company any information needed for this or a related Medicare/Other Insurance company claim. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare/Other Insurance Company assigned cases, the physician or supplier agrees to accept the charge determination of the Medical/Other Insurance Company as the full charge, and the patient is responsible only for deductibles, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/Other Insurance Company.

Signature \_\_\_\_\_ Date \_\_\_\_\_

If you are taking any medications please fill out the next form.

