Welcome to Our Office

Your Name:_____ Today's Date:_____
First Middle Last
Home Address:_____
City:_____ State:_____ Zip:_____
Home telephone:_____Cell phone:_____
Birth date:____/____/____Age:_____Sex: M____F____ Marital Status: S M_____
Social Security Number:_____
Employer:_____ Occupation:_____
Work Address:_____
City:_____ State:_____ Zip:_____
Work Telephone:(___)_____ E-Mail Address_____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party:_____ Relationship to Patient:_____
Address:_____
City:_____ State:_____ Zip:_____
Telephone:_____ Birth date:_____ Age:_____
Occupation:_____ Social Security Number:_____
Employer:_____Work Address:_____
City:_____ State:_____ Zip:_____
Work Telephone:(___)_____

Name of Spouse:_____Check here if same as above_____

In the case of an emergency, contact:
Check if same as above_____Name_____ Relationship:_____
Home Phone:_____ Work Phone:_____

How did you learn about Doctor Pearlman?

Physician Friend Website Newsletter Magazine Other

Referred by_____

Primary Physician:_____**Phone:**_____

Method of Payment:
_____ Cash _____ Check _____ Credit Card (MasterCard, VISA, American Express)

***Consultation Fees are due at time of service and are non-refundable. _____ (initial here)**

May we send correspondence to your home? Yes No
We are compliant with HIPAA (privacy of health information) if you desire a copy of the full notice please inquire.*Please Note: There are additional pages following to fill out for registration. Thank you
Steven Pearlman, M.D.

Confidential Patient Health Questionnaire

Patient Name:_____ Today's Date_____

Please <u>circle</u> those conditions pertinent to your medical history.

Head & Neck
- Eye disease
- Double vision
- Blurred vision
- Prior ear surgery
- Ear ache
- Hearing loss
- Dizziness
- Ringing or noise in ear
- Nasal obstruction
- Nosebleeds
- Nasal Discharge
- Altered sense of smell
- Sinusitis
- Nasal polyp[s
- Snoring
- Excessive daytime sleepiness
- Facial pain
- Pain with chewing
- Recent dental work
- Mouth/tongue sores or ulcers
- Lumps or swellings in the head or the neck
- Skin lesions that have changed recently
- Other _____

Respiratory System
- Hoarseness, over one week
- Chronic throat clearing
- Chronic cough
- Heartburn
- Regurgitation of food or liquids
- Coughing or spitting up blood
- Shortness of breath
- Wheezing
- Asthma
- Chronic bronchitis
- Emphysema
- Chest pain
- History of TB
- Positive TB Skin Test
- History of lung cancer
- Allergies to airborne (dust, pollens, molds, etc.)
- Other_____

Neurological
- Headaches
- Head injury
- Numbness or tingling
- Transient black outs
- Transient loss of vision
- Seizures
- Episodes of slurred speech
- Strokes
- History of brain surgery
- Brain tumors
- Memory loss
- Anxiety or depression
- Other_____

Cardiovascular System
- Hypertension
- Heart disease
- Angina
- Swelling of the ankles
- Heart surgery
- Angioplasty
- Pacemaker
- Shortness of breath on exertion
- Anemia or other blood disorder
- Mitro valve prolapse
- Other_____

Endocrine
- Diabetes
- Heat or cold intolerance
- Over- or underactive thyroid
- Menstrual disorders
- Discharge from breasts
- Other _____

Urogenital
- Difficulty or pain on urination
- Abnormal vaginal discharge or bleeding
- Frequent urination
- Blood in the urine
- Prostate problems
- Sexually transmitted diseases
- Other

General
- Night Sweats
- Fevers
- Skin Diseases
- Arthritis
- Bleeding disorder
- Easy brusability
- Previous blood transfusion
- HIV infection or AIDS
- Other_____

Gastrointestinal
- Heartburn or ulcers
- Difficult or pain on swallowing
- Chronic diarrhea or constipation
- Jaundice
- Liver disease
- Hepatitis
- Kidney disease
- Bloody stools
- Hemorrhoids
- Diverticulosis
- Gall bladder disease
- Other_____

CONTINUED →

Pearlman
Aesthetic Surgery

Please list **all** operations you have had, including cosmetic procedures._____

_____

_____

Please list **all** pills and medications you take regularly, as well as dose and frequency. (including over-the-counter medications, E.g.; Aspirin, Advil)._____

_____

Do you smoke? Amount?_____Do you drink alcohol? How much?_____

Do you use recreational drugs?_____

Please list **all** allergies (medications, inhalants, foods, contact allergies)_____

_____

Please describe any other problem which may not have been covered above, and which you would like the doctor to know about:_____

_____

Tell me why you are here today. What are your main concerns?_____

_____

_____

_____

Patient Signature_____ Today's Date_____

Physician Signature/Initials_____ Date Reviewed_____

CONTINUED →

Patient Consent Form: Use and Disclosure of
Health Information Protected under HIPAA

Pursuant to the information contained in the Notice of Privacy Practices, I give permission for the use and disclosure of Protected Health Information (PHI) in order to carry out Treatment, Payment, and Healthcare Operations (TPO).

I am aware that I have the right to review the Notice of Privacy Practices prior to signing this consent. Should the Notice of Privacy Practices be revised, I am aware that I may obtain a copy of the revised form by contacting the Medical Director of this facility.

I give my consent for this organization to contact me by calling my home or other designated location in order to leave a message (mechanically or with another person) or to speak to me directly regarding any matter which will help with the conduct of Treatment, Payment, and Healthcare Operations.

Further, I give my consent for the use of mail or e-mail to designated locations, including my home, to assist the organization in carrying out the described activities of Treatment, Payment, and Healthcare Operations.

I hereby consent to the use and disclosure of my PHI for the purpose of Treatment, Payment, and Healthcare Operations (TPO). This consent is good until revoked in writing, except to the extent that disclosures have been made in reliance upon my prior consent.

Services are provided without regard to sex, race, color, religion, national origin, or disability.

Dated:_____ Patient Name:_____

Patient Signature_____

If applicable, Legal Guardian_____

Steven Pearlman, M.D.

Insurance Information*

***Please check here if insurance is not being applied for visit/surgery** ☐

Your Name:_____ Today's Date:_____
First Middle Last

Primary Insurance:
Name and Address of Company:_____
City:_____ State:_____ Zip:_____

Insured's Name:_____

Group #:_____ Policy ID #:_____

Effective Date of Coverage:_____

Secondary Insurance:

Name and Address of Company:_____

City:_____ State:_____ Zip:_____

Insured's Name:_____

Group #:_____ Policy ID #:_____

Effective Date of Coverage:_____

Dr. Pearlman does not participate with any insurance other than Medicare. However, we may accept assignment if your insurance has out of network benefits. If applicable, our office will file insurance for you. **Office visits are payable at the time of service.**

A copy will be made of your insurance card to facilitate this process.

I authorize the release of any medical information necessary to process this claim.
Signed:_____
(Patient or authorized person)

Date:_____

I authorize payment of medical and procedure benefits to Steven Pearlman, MD.

Signed:_____
(Patient or authorized person)

Date:_____

*Two signatures may be necessary to process insurance claims