PATIENT REGISTRATION & HEALTH QUESTIONNAIRE

DATE					
NAME			MARITAL STATUS	DATE OF BIRTH	
STREET ADDRESS			CITY	STATE	ZIP
PHONE (HOME)	(WORK)		(CELL)	EMPLOYER	
S.S.#	EMAIL ADDRESS		REFERRED BY		
SPOUSE'S NAME	DATE OF BIRTH		OCCUPATION/EMPLOYER		PHONE
IF UNDER 18: PARENT/GUARDIAN					PHONE

INSURANCE & BILLING INFORMATION

BILLING NAME (IF OTHER THAN PATIENT)				RELATION
BILLING ADDRESS				PHONE #
DATE OF BIRTH	S.S.#			

PAYMENT REQUIRED AT TIME OF SERVICE – UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

1) INSURANCE COMPANY	ADDRESS			
SUBSCRIBER'S NAME		I.D.#	GROUP #	S.S.#
2) INSURANCE COMPANY	ADDRESS			
SUBSCRIBER'S NAME		I.D.#	GROUP #	S.S.#
MEDICARE #		**MEDICAID I.D. #**		
OTHER COVERAGE				

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical / medical benefits to **LISA F. SKLAR, M.D.** for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize **LISA F. SKLAR, M.D.** to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

MEDICARE ● MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

PATIENT ***(Please Print)***	**DATE**
PARENT/GUARDIAN ***(Please Print)***	**SIGNATURE**

SIGNATURE ON FILE FORM

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Lisa F. Sklar, M.D. for any services furnished to me by Dr. Sklar.

I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service.

_____ _____

Patient's Signature Date

MEDICAL HISTORY QUESTIONNAIRE **Date:**_____

Last name:_____ **First Name:**_____ **MI:**_____

Please Answer the Following Questions About Your Current Eye Problems and Medical History

1. What problems are you currently having with your eyes? **Which Eye?**

_____Floaters/Spots _____Pain

_____Flashing Lights _____Sensitivity to Light/Glare **Right**

_____Blurred Vision _____Poor Depth Perception

_____ Distortion/Waviness _____Trouble with Colors **Left**

_____Loss of Side Vision _____Other_____

When did the Trouble Begin?_____

2. Have you had any eye problems in the past (e.g. cataract, glaucoma, retina problems, eye surgery, etc.)?

_____Yes _____No **If yes, please explain**_____

_____

3. Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, heart disease, asthma, etc.)?

_____Yes _____No **If yes, please explain**_____

_____

4. Current Medication including eye drops:_____

_____

5. Do you have any allergies to medications?_____

6. Have you had any of the following?	**Yes**	**No**	**If yes, please explain:**
Chronic fever, unexpected weight loss/gain, fatigue?	___	___	_____
Ear/nose/throat problems (e.g. hearing loss, sinus problems)?	___	___	_____
Heart problems (e.g. chest pain, irregular heartbeat?)	___	___	_____
Respiratory problems (e.g. shortness of breath, wheezing, asthma, bronchitis)?	___	___	_____
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea)?	___	___	_____
Urinary problems (e.g. pain or discomfort bladder infections)?	___	___	_____
Skin disease (e.g. rashes, eczema, dermatitis)	___	___	_____
Musculoskeletal problems (e.g. muscle aches, arthritis, swollen joints)?	___	___	_____
Neurological problems (e.g. numbness, weakness, paralysis, headache)?	___	___	_____
Psychiatric problems (e.g. depression, anxiety)?	___	___	_____

7. Do any medical or eye diseases run in your family?

_____Yes _____No **If yes, please explain**_____

8. Do you smoke? ___ **If yes how much?** _____ _____**Drink alcohol? If yes, how much?**_____

_____**Reviewed by physician Comments:**_____