PATIENT REGISTRATION & HEALTH QUESTIONNAIRE

DATE				
NAME		MARITAL STATUS	DATE OF BIRTH	
STREET ADDRESS		CITY	STATE	ZIP
PHONE (HOME)	(WORK)	OCCUPATION	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 **MARK M. SKLAR, M.D., F.A.C.P.** 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 **MARK M. SKLAR, M.D., F.A.C.P.** 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**

HEALTH QUESTIONNAIRE

REASON FOR VISIT

FAMILY HISTORY

(IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING, PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE

1. EPILEPSY	6. THYROID	11. OSTEOPOROSIS	16. HIGH CHOLESTEROL
2. MIGRAINE	7. HAY FEVER	12. ARTHRITIS	17. ALCOHOLISM
3. MENTAL ILLNESS	8. ASTHMA	13. HEART DISEASE	18. CANCER
4. GLAUCOMA	9. ANEMIA	14. STROKE	19.
5. DIABETES	10. BLEEDS EASILY	15. HYPERTENSION	20.

HOSPITAL ADMISSIONS (not including pregnancies)

YEAR	*ILLNESS OR OPERATION*	*YEAR*	*ILLNESS OR OPERATION*

LIST ALL MEDICATIONS YOU ARE NOW TAKING – *INCLUDE THOSE YOU BUY WITHOUT A PRESCRIPTION*	**ALLERGIES**	**VACCINE**	**YEAR OF LAST**	**TEST/EXAM**	**YEAR OF LAST**
		TETANUS / TD		RECTAL/STOOL	
		INFLUENZA (FLU)		CHOLESTEROL	
		PNEUMONIA		EYE	
		HEPATITIS			
		TUBERCULOSIS			

MEDICAL HISTORY

(MARK (C) FOR CURRENT PROBLEMS. CHECK (✓) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.

- ☐ Decreased Hearing
- ☐ Ringing in Ear
- ☐ Ear Infections – *frequent*
- ☐ Dizzy Spells
- ☐ Fainting Spells
- ☐ Failing Vision
- ☐ Eye Pain
- ☐ Double or Blurred Vision
- ☐ Eye Infections – *frequent*
- ☐ Nose Bleeds – *recurrent*
- ☐ Sinus Trouble
- ☐ Sore Throats – *frequent*
- ☐ Hay Fever / Allergies
- ☐ Hoarseness – *prolonged*
- ☐ Pneumonia / Pleurisy
- ☐ Bronchitis / Chronic Cough
- ☐ Asthma / Wheezing
- ☐ Shortness of Breath:
  - ☐ on exertion ☐ lying flat
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Swollen Ankles
- ☐ Irregular Pulse
- ☐ Palpitations
- ☐ Leg Pain – *when walking*
- ☐ Varicose Veins / Phlebitis
- ☐ Loss of Appetite – *recent*
- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ Peptic Ulcer
- ☐ *Persistent* Nausea / Vomiting
- ☐ Abdominal Pain - *chronic*
- ☐ Gall Bladder Trouble
- ☐ Jaundice / Hepatitis
- ☐ Change in Bowel Habits
- ☐ Diarrhea
- ☐ Constipation
- ☐ Diverticulosis
- ☐ Crohn's / Colitis
- ☐ Bloody or Tarry Stools
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Urine Infections - *frequent*
- ☐ Blood in Urine
- ☐ Kidney Stones

Urination –

- ☐ Overnight > than twice
- ☐ Painful
- ☐ Loss of Control
- ☐ Decrease in force / flow

- ☐ Venereal Disease
- ☐ Urethral Discharge
- ☐ Chronic Fatigue
- ☐ Weight Loss - *recent*
- ☐ Anemia
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Seizures
- ☐ Stroke
- ☐ Tremor / Hands Shaking
- ☐ Muscle Weakness
- ☐ Numbing / Tingling Sensations
- ☐ Headaches - *frequent*
- ☐ Arthritis / Rheumatism
- ☐ Back Pain - *recurrent*
- ☐ Bone Fracture / Joint Injury
- ☐ Gout
- ☐ Osteoporosis
- ☐ Foot Pain
- ☐ Cold Numb Feet
- ☐ Rashes
- ☐ Hives
- ☐ Psoriasis
- ☐ Sleeping - *difficulty*
- ☐ Depression
- ☐ Nervousness
- ☐ Memory Loss
- ☐ Moodiness - *excessive*
- ☐ Mental Illness
- ☐ Phobias
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Chicken Pox
- ☐ Mumps
- ☐ Polio
- ☐ Measles
- ☐ German Measles
- ☐ Tuberculosis
- ☐ Herpes
- ☐ Alcohol _____ oz. per week
- ☐ Smoking
  - ____ cig/day _____ # years
  - ____ year quit
- ☐ Coffee / Tea
  - _____ cups per day
- ☐ Regular Exercise

MALES - ☐ Prostate PSA Test

FEMALES – *Please complete*

Menstrual Flow:

☐ Reg. ☐ Irreg. ☐ Pain/Cramps

Days of Flow _____

Length of Cycle _____

Date – 1st day of last period

_____

☐ Pain / Bleeding during or after sex

Number of:

_____ Pregnancies

_____ Abortions

_____ Miscarriages

_____ Live Births

Birth Control Method_____

B.C. Pill (Name):

_____

☐ Flushing / Menopause

Date of last PAP Test:

_____

☐ Normal ☐ Abnormal

Date of Last Mammogram

_____

☐ Normal ☐ Abnormal

NOTES

MARK M. SKLAR, M.D., F.A.C.P.

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Washington, DC 20037
(202) 887-4769

PATIENT RESPONSIBILITY

ARRIVING ON TIME

Out of respect for our patients' schedule, our office tries hard to be on time. Therefore, we request that patients arrive on time for their appointments. If you arrive more than 10 minutes late, you will be required to reschedule your appointment.

NO SHOW FEE

Our practice is very busy and we have many patients who are requesting appointments. Therefore, we find it frustrating when scheduled patients do not give us notice if they can not make their appointments. Notice given even the day before an appointment, allows us to give the time slot to another patient. As a result we instituted a **$50.00** charge for patients who do not show for their appointments or give at least a 24 hour notice of cancellation.

MEDICAL RECORDS FEE

There is a minimum $25.00 fee for medical records.

PRE AUTHORIZATIONS FEE

Preauthorization's can consume large amounts of the doctor's and his staff's time. Typically they involve waiting for and speaking with someone on the phone and in addition the process may require transmission of parts of the medical record. The time required for this process is not paid for by the insurance companies. Therefore, as compensation for the time spent by the doctor and his staff, we have instituted a **$50.00** fee for the preauthorization process.

CORRESPONDENCE

Patients wishing to have forms filled out, letters written or e-mail questions answered will be charged $25.00 to $100.00, depending on the time spent.

TELEPHONE CALLS

Patients requiring multiple or lengthy follow up calls during a short time span will be charged for these services. The fees can range from $25.00 to $100.00 depending on the length of the conversations. **INSURANCE WILL NOT PAY FOR THIS SERVICE; THE PATIENT IS RESPONSIBLE FOR THIS BALANCE**.

LAB COLLECTION FEE

I understand that certain PPO (Aetna, United Healthcare) and all HMO health plans require their members to go to an outside specified lab for collection of blood tests and other specimens. These health plans **do not pay** for specimen collection in the office. I understand that, as a convenience, if I want lab-work to be collected in Dr. Sklar's office and then sent to a participating lab, I will be responsible for a $**15.00 collection fee** due at the time of the visit. There will be a fee of **$30.00** due from patients wishing to have their blood drawn in the office when they do not see the doctor and we do not participate with their insurance companies.

REFERRAL

If your insurance company requires a referral for your visit with Dr. Sklar, you, as the patient, are responsible for obtaining a valid referral for **every visit**. If you do not bring a referral and wish to be seen, you are fully responsible for payment of **all** charges incurred during that visit.

INSURANCE PAYMENT

If we do not receive payment from your insurance company within **90 days**, you, as the patient, are responsible for paying the bill in full.

CREDIT CARD AUTHORIZATION

By signing this form below I authorize Dr. Sklar to charge my credit card when I call in my payment over the telephone. I understand that a receipt will be mailed to my address at my request.

CONSENT

By signing this form you, as the patient, authorized Dr. Sklar to file insurance claims on your behalf, receive payment from the insurance company and release medical records to the insurance company to expedite claim processing.

All of the above information is payable by the patient or patient's representative only.

I _____ have read and agree with the information above.
(Print Name)

Patient's Signature _____

Today's Date _____