Robert A. Sklar, M.D.
Diplomate – American Board of Ophthalmology

415 East Maple – Troy, Michigan
Phone (248) 526-1010

WELCOME

To the office of Dr. Robert A. Sklar and Troy Optical

Enclosed are registration forms, which you need to complete prior to your appointment. Please bring them with you on the day of your exam.

Appointment Date:_____Time:_____

Please allow 2 hours for your examination.

- If you wear glasses, please bring them to your appointment.

- If you are taking any medications, please bring a list with you.

- If you are a contact lens wearer, please Do Not Wear them on the day of your exam. Please bring a copy of your prescription and/or your packages from your lenses.

We will call you 1-2 days before your appointment to confirm the date and time. If you need to reschedule your appointment please give us 48 hours notice.

OUR MISSION IS TO PROVIDE YOU WITH EXCELLENCE IN EYE CARE

As a patient you can expect:
Dr. Sklar's commitment to combine his expertise with the latest technology to treat your eye care needs
A highly trained and caring support staff
A friendly smile
A courteous manner
To be treated as an individual

We appreciate your choosing us to be the provider of your eye care needs

Thank You
Dr. Sklar and Staff

Patient Information

Patient Name:_____ ☐ Male ☐ Female
FIRST MIDDLE LAST

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐Other_____

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐Fr. ☐ Rev. ☐ Other_____

Date Of Birth _____/_____/_____ Spouse Date of Birth _____/_____/_____

SS# _____ - _____ - _____ (required for billing) Spouse SS# _____ - _____ - _____

Address: _____

City: _____ State:_____ Zip: _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____

Cell Phone (_____) _____-_____ E-Mail Address_____

Employer Name_____

Address_____ City _____ State_____ Zip_____

Spouse Name_____

Emergency Contact_____ Phone(_____)_____-_____

Who referred you to us?_____

Are you allergic to any medication?_____

Family Doctor_____

Who is responsible for the charges?_____

Primary Insurance_____ Secondary Insurance_____

*** Please Give Your Insurance Cards to the Receptionist***

Please remember that it is your responsibility to be aware of the terms of your insurance coverage. I agree to be responsible for the payment of any charges not covered by my insurance company. I give Robert A. Sklar MD permission to forward any medical records to my ins company in the event they are required.

Signature_____ Date_____

Updated_____

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date _____

Date of **Birth** _____ Date of **last eye exam** _____

List any **medications** you currently take (Rx and over-the-counter): _____

_____

Do you have **allergies** to any medications? **YES** **NO**
If YES, list the medications: _____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):

_____

List any **surgeries** you have had (cataract, appendectomy): _____

Do you ***currently*** have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply) ? **YES** **NO** **UNKNOWN**

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Other heritable disease:

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES** **NO**
Have you ever had a blood transfusion?..... **YES** **NO**
Do you drink alcohol?..... **YES** **NO** If YES, how much? _____
Do you smoke?..... **YES** **NO** If YES, how much? _____ How many years? _____

Physician's Signature _____ *Date* _____

Robert A. Sklar, M.D.
Authorization for Release of Information

Patient Name_____

DOB_____ Account #_____

I authorize the following person(s) to receive information on my behalf. Including but not limited to account balance, test results, diagnoses, and/or treatment. This authorization shall remain in effect until revoked in writing by me.

1_____

2_____

3_____

4_____

Patient Signature_____

Date_____

Witness Signature_____

Date_____

Robert A. Sklar, M.D. P.C.

Dear Patient:

For your convenience and safety, we are introducing a computerized prescription program that will improve both the accuracy and convenience of prescribing medications. This program will allow for the electronic transmission of most of your prescriptions directly to your pharmacy of choice and will eliminate your waiting time. In most cases, it will also accommodate the transmissions of your prescription to mail order pharmacies.

To implement this new program, we need to collect some information from you on your pharmacies of choice. We will define one pharmacy as your main pharmacy; however, you may also provide the information for additional pharmacies to be used as an alternative. In addition, if you have a mail order benefit program, please provide that information by selecting the appropriate box below.

We understand that you may not have the complete pharmacy information with you today. Please provide any information possible regarding the location (street, city, phone, fax) as any information provided will be helpful.

PATIENT NAME:_____Date of Birth:_____

MAIN PHARMACY:

Name (i.e. CVS, Rite Aid, etc):_____
Street Name & City:_____
Phone:_____Fax:_____

ADDITIONAL PHARMACIES YOU WOULD LIKE KEPT ON FILE:

Name (i.e. CVS, Rite-Aid, etc):_____
Street Name & City:_____
Phone:_____Fax:_____

Name (i.e. CVS, Rite Aid, etc):_____
Street Name & City:_____
Phone:_____Fax:_____

MAIL ORDER:

Express Scripts, Inc.

CareMark/ Pharmacare

Other_____

Please list your drug allergies:

_____

_____

_____