Medical Questionnaire

RAMIREZ & POULOS
MD | PA

_____
Patient Name

Reason for today's visit_____

Do you currently have any of the following symptoms? Check all that apply

☐ Blurred Vision ☐ Difficulty Reading ☐Glare ☐ Night driving ☐Double Vision ☐Flashes / Floaters

☐Eye pain ☐Foreign body sensation ☐Red eyes ☐Itchy eyes ☐Tearing ☐ Dry Eyes

Do you wear glasses? **Yes / No** Do you wear contacts? **Yes / No** Brand: _____

History of **Eye Disease** Self or Family including Parents, Grandparents, Siblings

☐Glaucoma ☐Macular Degeneration ☐Retinal Detachment ☐Strabismus (eye turn) ☐Blindness ☐None

Eye Surgeries: _____☐None

Medications for Eyes: _____☐None

Medical Conditions: ☐Diabetes last A1c_____ ☐Hypertension ☐Stroke ☐heart disease ☐Irregular heartbeat /Arrhythmia ☐Stents ☐lung disease ☐Cancer_____ ☐Arthritis ☐kidney disease /kidney stones ☐Thyroid ☐Migraines ☐Anemia ☐blood disorder ☐HIV/AIDS ☐Infectious disease_____ ☐Autoimmune disease ☐Seasonal / Environmental allergies ☐None

Major Surgeries: _____ ☐None

Allergies to medications: ☐NKDA

Name	Reaction	Name	Reaction

Medications: Any Prostate Medications: ☐Flomax (Tamsulosin) ☐Hytrin ☐Cardura ☐Rapaflo ☐Uroxatrol

Social: Smoking: ☐Yes ☐No ☐Former Alcohol: ☐Yes ☐None Driving: ☐Yes ☐No Pregnant? ☐Yes ☐No

Pharmacy Name: _____ Pharmacy Number: _____

PCP: _____ Endocrinologist: _____ Rheumatologist: _____

Review of Systems: Do you currently have problems with any of the following? Check all that apply.

☐Gastrointestinal ☐Cardiovascular ☐Ear/Nose/Throat ☐Musculoskeletal ☐Nervous ☐Mental ☐Blood/ lymph ☐Respiratory ☐Headaches ☐ No symptoms currently / general good health

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Patient Registration Form

Printed Last Name: _____ **First Name**: _____**MI**:_____

Date of Birth: _____ **Social Security Number (optional)**:_____

Contact: Phone: (_____)_____ Email: _____

Mailing Address: Street _____ Apartment Number_____

City_____ State_____ Zip_____-_____

If your mailing address is different than your address on your insurance card provide it below:

Street _____ Apartment #_____ City_____ State_____ Zip_____

Emergency Contact: First Name:_____Last Name_____

Phone Number: (_____)_____Relationship:_____

Primary Care Physician: _____**Referred By**:_____

Preferred Language:_____ **Race:**_____ **Ethnicity:**_____

Gender: Male Female Other Choose not to disclose

Insurance: Add additional info if you are not the insurance subscriber or patient is a minor, we cannot bill insurance without this.

Subscriber First Name: _____Last Name _____

Date of Birth:_____ Relationship:_____Gender_____

Responsible Party:_____

Signature: _____ **Date:**_____

Parent / Guardian Printed Name if signing for patient: _____

RAMIREZ & POULOS
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Photo identification and a current insurance card are required at the time of your visit.

Insurance Waiver: Many insurance companies charge a co-payment, coinsurance, and or a deductible for services rendered, as we are a specialist office many patients will have diagnostic procedures and testing along with their office visit. We make every effort to verify your insurance status prior to your visit: however, it is your responsibility to determine the status of coverage (co-pays, deductibles, etc.) prior to your visit. Ramirez & Poulos will submit the claim on your behalf, and you will be responsible if there are additional charges not collected at the time of service based on the explanation of benefits notice we receive from your insurance company. Should you receive a bill for any additional amount, it is based on your insurance plan's determination. **I hereby assign all benefits to Ramirez & Poulos, MD PA. I understand that I am responsible for my co-payment, coinsurance, and / or deductible at the time of service.**

Financial Policy: We ask that you assist us in achieving our goals of providing our patients with the highest quality of ophthalmic care by complying with our financial policy. Costs for services are due at the time of service. We appreciate prompt payment in full for any outstanding balance. If you are unable to pay the balance in full, notify our billing department immediately. If your account is turned over to our collection agency you agree to pay any fees imposed by the collection agency. Returned checks will be subject to a **$30.00 return check fee**.

Cancellation / No show Policy: There will be a **$50.00 charge** if you fail to show for a scheduled appointment or cancel the same day of your appointment. Any patient that cancels a scheduled surgery with less than one week notice or does not show for a scheduled **surgery will be charged $150.00 cancellation fee**. These fees are not covered by your insurance. Legitimate emergencies will be considered.

Forms: We will be happy to complete forms such as FMLA, DMV, and insurance forms, the fee for these services is $25.00 per form, the expected turnaround is 5-7 business days.

Refraction:

A refraction is a diagnostic tool used to determine a patient's best ability to see. It is necessary to perform the test for your physician to determine the best possible vision needed to assess eye diseases. The refraction does not always lead to a prescription being given. Most insurance companies including Medicare do not cover the refraction test.

Our fee for the refraction is $50.00.
Our fee for contact lens renewal which includes the refraction is $80.00.

Information and Consent for Dilated Eye Examination:

Dilating drops are used to enlarge the pupil of the eye to allow the doctor to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your doctor to predict how much your vision will be affected. Driving may be difficult immediately after examination and you may want to make arrangements, so you do not have to drive yourself. Adverse reactions, such as acute angle-closure glaucoma may be triggered by dilation drops. This is extremely rare and treatable with immediate medical attention.

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Authorization to release / receive health information: Due to the HIPAA Compliance Privacy Act of the federal government, it is mandatory that *Ramirez and Poulos, MD PA* ask you to review and to answer the following questions.

- May we leave messages / medical information on your voicemail? ☐ **Yes** ☐ **No**
- If you authorize us to receive and discuss your personal health information with anyone list them below.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If the patient is a minor, list parents or guardians' names entitled to medical information.

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

If there is a person with power of attorney for medical purposes, documentation must be provided to be kept on file.

I, _____acknowledge I have read and reviewed all the information and office policies above.

_____ _____

Signature **Date**

7/10/2023