RICARDO J. RAMIREZ, M.D. MARGARET K. POULOS, M.D.

PATIENT INFORMATION SHEET

First Name: _____ MI: _____ Last Name: _____ Soc. Security #: _____

Telephone: ( ) _____ **Cell Ph:** ( ) _____ **Email:** _____

Street Address: _____ P.O. Box (if applicable): _____

City: _____ State: _____ Zip Code: _____

Sex: ☐ M • ☐ F Marital Status: ☐ Single • ☐ Married • ☐ Widowed • ☐ Divorced DOB: _____ Age: _____

If you have been seen here previously, under what name: _____

Emergency Contact: _____ Relationship: _____

Home Telephone: ( ) _____ Cell Phone: ( ) _____

Referred by: _____ **Family Physician:** _____ **Phone #** ( ) _____

Cardiologist: _____ **Phone #** ( ) _____

EMPLOYER INFORMATION:

Employer's Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Telephone: ( ) _____

Occupation: _____

INSURANCE INFORMATION:

Insurance Company: _____ Name of Policyholder: _____ **Date of Birth:** _____

Telephone: ( ) _____

Policy Number: _____ Group Number: _____

RESPONSIBLE PARTY / PARENT / SPOUSE:

Name: _____ Relationship: _____

Telephone: ( ) _____

Date of Birth: _____

Social Security #: _____

MEDICARE INFORMATION:

Medicare Number: _____ Medicaid Number: _____

SUPPLEMENTAL INSURANCE INFORMATION:

Insurance Company: _____ Name of Policyholder: _____ **Date of Birth:** _____

Telephone: ( ) _____

Policy Number: _____ Group Number: _____

AUTHORIZATIONS

"I hereby authorize the Physicians and staff of ***Ramirez & Poulos, M.D., P.A.*** to perform such treatments to me as may be prescribed by my attending physician during any and all my visits to ***Ramirez & Poulos, M.D., P.A.***"

"I understand that I am financially responsible for **ALL** charges arising from services rendered to me by ***Ramirez & Poulos, M.D., P.A.***"

PATIENT'S SIGNATURE: X _____ **Date:** _____ **20** _____

BLANKET ASSIGNMENT

"I HEREBY AUTHORIZE ***Ramirez & Poulos, M.D., P.A.*** TO FILE ON ANY AND ALL INSURANCE FOR ANY CHARGES THAT INCUR. I REQUEST THAT ALL PAYMENTS FROM ANY OF THESE INSURANCES BE MAILED DIRECTLY TO ***Ramirez & Poulos, M.D., P.A.*** I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS, OR ANY INSURANCE COMPANY, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

PATIENT'S SIGNATURE: X _____ **Date:** _____ **20** _____

Name: _____ Date: _____

PATIENT HISTORY QUESTIONNAIRE

Medical, Family & Social History: Please check the following as they apply to **Self (S)** or to your **Family (F)**:

	S	F		S	F		S	F
High Blood Pressure			**Kidney Disease**			**Bleeding Disorders**		
Heart Attack			**Stroke**			**Arthritis Type** _____		
Irregular Heart Beat			**Thyroid Disease**			**HIV Positive**		
Diabetes			**Cancer**			**Hepatitis A B C Positive** (circle all that apply)		
Breathing Problem			**Ulcers**			**Other (Specify)**		

Previous Operations and Dates: _____

_____

_____

Allergic to medications (LIST MEDS): _____

_____

Latex Allergies? ☐ **Yes** ☐ **No**

Have you ever taken Flomax? ☐ **Yes** ☐ **No**

When and how long? _____

Present Medications (Include non-prescription drugs)

_____

_____

_____

_____

_____

Power of Attorney? ☐ **Yes** ☐ **No** **Who?** _____

Do you wear contact lenses ☐ No ☐ Yes - How long? _____ years ☐ Hard ☐ Soft

When was your last eye exam? _____ **With whom:** _____

When was your last change in eyeglasses? _____

Eye History – Self (S) or Family (F)

	S	F
Cataract		
Glaucoma		
Diabetic Retinopathy		
Lazy Eye or Strabismus		
Macular Degeneration		
Retinal Detachment		
Injury		
Other (Specify)		

Previous Eye Surgery

_____

_____

_____

_____

Present Eye Medications

_____

_____

_____

_____

Please check Yes or No – Explain any Yes

Do you use street drugs? ☐ No ☐ Yes _____

Do you drink alcohol? ☐ No ☐ Yes - how much _____

Do you smoke? ☐ No ☐ Yes - how much _____