WELCOME TO THE OFFICE

Tell us about yourself:

Patient's Name ____________________

Address ____________________

City ____________ State ________ Zip Code ________

Home ____________ Cell ____________ Work ____________

Email Address ____________________

Date of Birth ________ Age _____ Sex *(Please Circle)* M or F

Occupation ____________

Complete if under 18 years or a student

Name of Father ____________ Employer ____________

Address ____________ Phone (___) ____________

Name of Mother ____________ Employer ____________

Address ____________ Phone (___) ____________

Who may we thank for your referral? ____________________

Physician

Primary Doctor ____________ Address ____________

Tell us about your insurance: (Please present insurance information before examination)

Primary Medical Insurance ____________________

Subscriber Name ____________________

Subscriber SSN ____________ Subscriber Birth Date ____________

Secondary or Supplemental policy? Yes or No If yes list: ____________

This office complies with HIPPA and you may have a copy of the Notice of Privacy Practice that is posted in the office (Circle or Check)

I want a copy   Do not want a copy

By intialing below I hereby the following have been read and agreed to.

1. ________ Financial Assignment and Agreement (See Attached)
2. ________ Notice of Privacy Rights (HIPPA) (See Attached)
3. ________ Authorization to Release Confidential Information (See Attached)
4. ________ Information Regarding Dilating Eye Drops (See Attached)
   Authorizing Dr. Ruben E. Ramirez or Dr. Monica V. Ramirez to administer dilating eye drops if either of them deem necessary for today's examination. The eye drops may be necessary to diagnose my condition.
5. ________ Notice Regarding Refraction Fees (See Attached)
6. ________ Important Medical Insurance Information (See Attached)

____________________ Signature

____________________ Name (Printed)

____________________ Witness

____________________ Date

TURN OVER (continued on next page)

Account No: ____________

DOB: ____________

Financial Assignment and Agreement

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. What we as medical professionals see as medically necessary, May not be what your insurance plans agrees with medically necessary and therefore will treat as a "non-covered investigational service". Ultimately it is our duty to inform you of the services available to provide you with the best care so that you can make an informed decision about your health. **It is your responsibility to pay any amount, co-insurance, or any other balance not paid for by your insurance. In the event of payment by insurance and patient over payment please allow 90 days from receipt of insurance payment to process patient refund requests. Please note that bounced checks will be assessed a $25.00 fee.**

In order to control cost of billings, we request that your charges for office visits be paid at the conclusion of each visit, this includes co-insurance and deductable applicable to each visit.

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Authorize to Release Confidential Information

I authorize Ruben E. Ramirez, M.D. and/or Monica V. Ramirez, O.D. and/or the staff of Buena Vista Eye Care to disclose information and records regarding my medical condition and medical and surgical treatment(s) to my other health-care providers and to my insurance carriers.

Information Regarding Dilating Eye Drops

Dilating drops are used to dilate or enlarge the pupils of the eye to allow eye doctor to get a better view of the inside of your eye. **Not all insurance panels view this as a covered service for your exam, if so, then there will be a $15.00 charge**. 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 eye doctor to predict how much your vision will be affected. Because driving may be difficult immediately after examination, you are advised not to drive yourself for 24 hours after your examination today. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and usually treatable with immediate medical attention.

Notice Regarding Refraction Fees

I understand that payment for the refraction (eyeglass prescription) portion of a complete eye examination is usually not covered by medical insurance and is my responsibility. **The usual charge for this service is $50.00.**

Important Medical Insurance Information

1. Some procedures require an additional payment separate from your co-pay. (This is considered under your insurance to be a co-insurance or deductible).
2. Some procedures might not be covered by your insurance and might leave a responsible balance on your account once we receive an EOB (explanation of benefits) from your insurance.
3. Medicare Patients: It is your responsibility to notify the office if you have changed your plan to an HMO/Manage care.
4. Routine physical exams are not always covered by your insurance. (Please check with your insurance company, you may be expected to pay in full the day of your exam).
5. Our preferred Facilities are: *El Paso Day Surgery, Surgical Center of El Paso, UMC, and Sierra.*

ARRIVED: ____________ SCHEDULED: ______________ ACCOUNT: ____________________

Patient Name: ____ **DOB:** ____________________

HOW CAN WE HELP YOU TODAY?

*** Medical insurance will only cover if there is a medical reason for the exam such as loss of vision, headaches, eye redness, eye pain, eye itching or burning, glaucoma, cataracts, floaters, dry eyes.***

Who referred you to us? ____

What signs and symptoms are you experiencing? ____

____

Which eye? ____

For how long? ____

Is it getting better or worse? ____

What have you tried to improve the situation? ____

Interested in contact lenses? ____

____

PAST HISTORY

List all major injuries, surgeries and/or hospitalizations:

____

____

____

SELF AND FAMILY MEDICAL & EYE HISTORY

Is there personal or family medical history of any of the following? If so, what is the relationship?

	FAMILY	SELF		FAMILY	SELF
Glaucoma:			**Lazy Eye:**		
Cataracts:			**Diabetes:**		
Macular Degeneration:			**Cancer:**		
Eye injury:			**Heart Disease:**		
Retinal disease:			**Hypertension:**		
Blindness:			**High cholesterol:**		
Crossed Eyes:			**Thyroid Disease:**		
Other:			**Arthritis:**		

OFFICE USE ONLY

	NEEDS	DONE		NEEDS	DONE
AR:			**FUNDUS:**		
TOPOGRAPHY:			**REFRACTION:**		
FDT:			**HVF:**		
ECC:			**BSCAN:**		
OCT :			**IOL MASTER:**		

OPTICAL: __________ OK REFRACTION: ____ DILATION: ____________ ROOM: ________________

RETURN: DAYS______ WEEKS______ MONTH ______ REASON/STUDY________________

Review Of Systems:
Please check applicable symptoms:

Eyes

Y N
[ ] [ ] Blur
[ ] [ ] Double vision
[ ] [ ] Flashes/floaters
[ ] [ ] Dry eyes
[ ] [ ] Red/watery eyes
[ ] [ ] Burning/itching
[ ] [ ] Discharge
[ ] [ ] Light sensitivity
[ ] [ ] Glare/halos
[ ] [ ] Tired eyes
[ ] [ ] Eye soreness

Constitutional
[ ] [ ] Fever/chills
[ ] [ ] Fatigue/malaise
[ ] [ ] Weight loss/gain

Cardiovascular
[ ] [ ] Chest pain
[ ] [ ] Palpitations
[ ] [ ] Leg/arm swelling

Ear/Nose/Throat
[ ] [ ] Dry throat/ mouth
[ ] [ ] Hearing loss
[ ] [ ] Sore throat/cough
[ ] [ ] Difficulty swallowing
[ ] [ ] Abnormal taste

Respiratory
[ ] [ ] Asthma
[ ] [ ] Shortness of breath

Gastrointestinal

Y N
[ ] [ ] Diarrhea
[ ] [ ] Constipation
[ ] [ ] Heart burn
[ ] [ ] Abdominal pain

Genitourinary
[ ] [ ] bladder problems
[ ] [ ] pain on urination
[ ] [ ] kidney problems

Musculoskeletal
[ ] [ ] Muscle pain
[ ] [ ] Joint pain
[ ] [ ] Headache

Integumentary
[ ] [ ] Rashes/sores
[ ] [ ] Skin dryness
[ ] [ ] Brittlenails/hair

Neorological
[ ] [ ] Migraines
[ ] [ ] Seizures
[ ] [ ] Numbness
[ ] [ ] Paralysis

Psychiatric
[ ] [ ] Mood changes
[ ] [ ] Anxiety
[ ] [ ] Depression

Endocrine
[ ] [ ] Frequent urination
[ ] [ ] Frequent thirst
[ ] [ ] Heat/cold intolerance

Hematologic/lymphatic
[ ] [ ] Anemia
[ ] [ ] Bleeding problems
[ ] [ ] Node swelling

Allergic immunologic
[ ] [ ] Hay fever
[ ] [ ] Sinus problems

Are you pregnant?
Yes___ No___

If so, are you nursing?

Yes___No___

Contact Lens Wearer?
Yes___ No___

If yes, what contact solution are you currently using?

____

____

Soft or rigid lenses?

____

Medical History

List any medications you take and for what illness (including aspirin, home remedies oral contraceptives, over the counter meds)

____

____

____

____

____

List any eye medications

____

____

____

Do you have any allergies to medications?

Yes _____ No _____

Which______________________

____

____

____

Social History

this is confidential and may be discussed directly with the doctor if desired

Past or current activities

Do you use any of the following?

Y N
[ ] [ ] Tobacco
[ ] [ ] Alcohol
[ ] [ ] Illegal drugs

Have you been exposed/infected with?
[ ] [ ] Gonorrhea
[ ] [ ] Hepatitis
[ ] [ ] HIV
[ ] [ ] Syphilis