BRANDON SUEDEKUM M.D.
Patient-Centered Cataract Surgery

Date: _____

Name: _____Age: _____DOB: _____

Address: _____

Home Phone: _____

Cell Phone: _____ Email: _____

Primary Insurance: _____

ID #: _____ Group #: _____

Medical Claims Address: _____

Secondary Insurance: _____

ID #: _____ Group #: _____

Medical Claims Address: _____

Emergency Contact | Medical Records Access

Name: _____ Phone #: _____

Relationship: _____ Access to medical records? ☐ YES ☐ NO

Who referred you to this office? _____

Race		**Ethnicity**
❑ White	❑ Black or African American	❑ Hispanic or Latino
❑ Hispanic	❑ Native Hawaiian or Pacific Islander	❑ Non-Hispanic or Latino
❑ Asian	❑ American Indian or Alaskan Native	

NAME:_____ DATE:_____

AGE:_____ WEIGHT:_____ HEIGHT:_____ CONTACTS: ☐ RIGHT ☐ LEFT

DENTURES: ☐ UPPER ☐ LOWER HEARING AIDS: ☐ RIGHT ☐ LEFT

DOCTORS

Please list all the doctors involved in your care.

NAME	REASON (ex. heart, diabetes)

MEDICATION ALLERGIES ☐**NO KNOWN ALLERGIES**

List of Allergies	Reaction

Are you sensitive to any of the following?

☐Iodine
☐Topical Injected IV
☐Tape Reaction
☐Latex

ANESTHESIA REACTIONS:

Have you had any complication related to anesthesia? ☐ Yes ☐ No ☐ General ☐ Local

Describe reaction:_____

Malignant Hyperthermia ☐ Yes ☐ No

Family Member with Complications Related to Anesthesia ☐ Yes ☐ No

Describe reaction:_____

MEDICAL HISTORY **PLEASE CHECK ALL THAT APPLY**

HEART AND VASCULAR
- ❑ Heart Attack(s) (Dates): _____
- ❑ Angina/Chest Pain
- ❑ Murmur
- ❑ Abnormal Rhythm
- ❑ High Blood Pressure
- ❑ Heart Failure
- ❑ Pacemaker
- ❑ Mitral Valve Prolapse
- ❑ High Cholesterol
- ❑ Other:_____

LUNGS
- ❑ Asthma/Wheezing
- ❑ Emphysema
- ❑ Bronchitis
- ❑ Chronic Cough
- ❑ TB (or Family History)
- ❑ Shortness of Breath
- ❑ Recent Cough/Cold
- ❑ Sleep Apnea
- ❑ Other: _____

GENITAL/URINARY
- ❑ Kidney or Renal
- ❑ Dialysis Schedule: _____
- ❑ Other:_____

GASTRO-INTESTINAL
- ❑ Liver Disease
- ❑ Jaundice
- ❑ Hiatal Hernia/Reflux
- ❑ Other:_____

BLOOD AND COAGULATION
- ❑ Aids/HIV
- ❑ Hepatitis Type: _____
- ❑ Anemia
- ❑ Bruising
- ❑ Other:_____

NERVOUS SYSTEM
- ❑ Stroke
- ❑ Seizures/Epilepsy
- ❑ Head/Neck Injury
- ❑ Other: _____

ENDOCRINE
- ❑ Diabetes
- ❑ Insulin
- ❑ Thyroid Disease
- ❑ Other:_____

MUSCULO-SKELETAL SYSTEM
- ❑ Chronic Back or Neck Trouble
- ❑ Arthritis
- ❑ Multiple Sclerosis
- ❑ Other:_____

OTHER
- ❑ Glaucoma: ☐Rt ☐Lt
- ❑ Hearing Loss: ☐Rt ☐Lt
- ❑ Breast Feeding
- ❑ Cancer: Type _____
- ❑ Pregnant
- ❑ Other: _____

DO YOU SMOKE? ☐ YES ☐ NO If yes, what quantity?_____

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO If yes, what quantity?_____

DO YOU USE RECREATIONAL DRUGS? ☐ YES ☐ NO

_____

SIGNATURE OF PATIENT OR GUARDIAN DATE

MEDICATIONS: ☐ **I DO NOT TAKE ANY MEDICATIONS**

Please list all the medicines you take which require a doctor's prescription.

NAME OF MEDICATION	DOSE OF MEDICINE Mg, units, cc's	HOW OFTEN TAKEN

PLEASE CHECK ANY OVER- THE-COUNTER MEDICINES YOU ARE PRESENTLY TAKING:

- ❑ *NONE*
- ❑ Antacids
- ❑ Aspirin Containing Products
- ❑ Cold/Cough remedies
- ❑ Diarrhea Preparations
- ❑ Eye Drops
- ❑ Herbal Remedies
- ❑ Laxative
- ❑ Pain Medicines
- ❑ Sleeping Medicine
- ❑ Vitamin/Supplements
- ❑ Recreational Drugs
- ❑ Weight Loss Medications
- ❑ Other: _____

Have you taken any blood thinner or aspirin in the last 3 months? ☐ Yes ☐ No

SURGICAL HISTORY:

LIST PREVIOUS SURGERIES/INJURIES/HOSPITALIZATIONS OR PROCEEDURES (INCLUDE EYE SURGERIES) ☐ NONE

DATE	PROCEDURES

HAVE YOU OR ANY MEMBER OF YOUR FAMILY BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

M=Mother F=Father S=Sibling GP=Grandparent

	SELF	FAMILY		SELF	FAMILY
CATARACTS			CONJUCTIVITIS (PINK EYE)		
GLAUCOMA			RETINAL DISEASE		
CORNEAL DYSTROPHY			RETINAL DETACHMENT		
KERATACONUS			INJURY		
DRY EYE			LAZY/CROSSED EYE		
INFECTION EYE LID			OTHER		

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LIFETIME SIGNATURE AUTHORIZATION

Patient Name (Printed)

I request that payment of benefits be made on my behalf (on assigned claims) to Brandon Suedekum, M.D. PC for any services furnished to me by physicians in the aforementioned entity. I further agree that I am responsible for payment of charges incurred by me that are outside of the scope of my insurance coverage or for which my insurance company has paid me. If I have had previous refractive surgery, I understand that this may affect my insurance coverage and I could be responsible for the payment.

I hereby authorize Brandon Suedekum, M.D. PC to release information acquired during the course of my examination or treatment to my referring physician or to an appropriate insurance carrier. If a Medicare patient, I further authorize release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services.

I authorize Brandon K. Suedekum, M.D. to use eScript to retrieve my medication history.

I authorize Brandon Suedekum, M.D. PC to leave reminder messages on my answering devices for appointments.

I consent to receive medical care by Brandon Suedekum, M.D. PC and its affiliates. I hereby authorize medical treatment by the physician, the clinical staff and technical employees assigned to my care. I authorize my treating providers to order any ancillary services deemed necessary for my care and treatment. I understand that I have the right and the opportunity to discuss alternative plans of treatment with my physician or other healthcare provider and to ask and have answered to my satisfaction any questions or concerns.

Date **Signature**

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Acknowledgement of Receipt of Privacy Notice

Original to be maintained in patient's permanent medical record

I acknowledge that I have received a copy of the office's Notice of Privacy Practices

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed Name if signed on behalf of the patient. Relationship to patient

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Patient Pharmacy Information

Date: _____

Patient Name: _____

Pharmacy Name: _____

Pharmacy *street* Address: Please put cross streets if you do not have the address.

_____

_____

Pharmacy Phone Number: _____

Mail In Pharmacy Information

Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy Fax Number: _____

Is this a work-related visit filed under workman's comp or an industrial injury? YES ☐ NO ☐