SIEDLECKI
CATARACT & VISION CARE
OUR FAMILY CARING FOR YOURS

- Andrew J. Siedlecki, M.D.
- Andrew N. Siedlecki, M.D.
- Andrew A. Pasquale, M.D.

Thank you for choosing Siedlecki Cataract & Vision Care as your eye care professionals!

Please take a few moments to complete the enclosed forms. The patient information is kept strictly confidential. When you come for your appointment, please bring with you the following:

1. Completed and signed "Patient History & Information" Form.
2. Insurance card (s).
    a. Please check with your insurance carrier to see if you have coverage.
    b. If a referral is required, please contact your primary doctor before your appointment.
3. Photo ID.
4. Current eyeglasses/or current prescription.
5. Applicable co-payment is due at the time of service.
6. Please anticipate that your eyes will be dilated for this appointment. For safety reasons, we recommend you have a driver accompany you.

We look forward to seeing you and thank you for your cooperation regarding the above.

Siedlecki Cataract and Vision Care

PLEASE DO NOT MAIL FORMS BACK, PLEASE BRING THEM WITH YOU TO YOUR APPOINTMENT. A $40.00 FEE WILL BE CHARGED FOR ANY NO-SHOW APPOINTMENTS

PLEASE CANCEL APPOINTMENTS 24 HOURS IN ADVANCE.

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IT IS IMPORTANT WE HAVE YOUR PRIMARY CARE PHYSICIAN'S INFORMATION. PLEASE COMPLETE THIS FORM.

PATIENT'S NAME _____

DATE OF BIRTH _____

PRIMARY CARE DOCTOR: _____

ADDRESS:

STREET _____

CITY/STATE/ZIP: _____

_____

PHONE NUMBER: _____

BRING COMPLETED FORM TO YOUR APPOINTMENT

Medical Offices
2875 Niagara Falls Blvd, Amherst, NY 14228
3349 Southwestern Blvd, Orchard Park, NY 14127
(716) 634-8500

Surgery Centers
170 Maple Rd, Getzville, NY 14221
3349 Southwestern Blvd, Orchard Park, NY 14127
(716) 632-2020

www.EyesOnBuffalo.com

Ambulatory Surgery Center: Patient History and Medical Information

❑Male
❑Female

Name: _____ Date of Birth: _____

Current Height: ___ ft. _____ in. Current Weight: _____lbs. Primary Language: _____

Email Address: _____ Primary MD: _____

Emergency Contact: Name_____ Relationship _____ Phone _____

For NYS Reporting, circle one: White, Black/African American, Asian, Hispanic/Latino, Native Hawaiian/Other Pacific Islander, Other, Declined/Unk

HOSPITALIZATIONS/SURGERIES (Include cardiac procedures, angioplasty, stents, cataracts, etc.)

	DATE	SURGERY OR REASON FOR HOSPITALIZATION
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Have you or any family members ever experienced problems while under anesthesia such as a high fever or irregular heartbeat? ❑ Yes ❑ No

If Yes, please state what happened: _____

WOMEN: ❑ I no longer menstruate. ❑ I do menstruate and understand I will be required to have a urine pregnancy test prior to surgery in order to receive IV sedation.
I do menstruate however I am ❑ actively using birth control ❑ not sexually active ❑ infertile.

Medication Reconciliation Record. List all the medications you are currently taking including all prescription meds, vitamins and supplements and over-the-counter medications.

You do not need to include medications that were ordered for this procedure. Attach additional page if necessary.

MEDICATION NAME Include vitamins & herbal supplements, OTC	Dose/ Freq.	Reason/ Purpose	{FOR OFFICE USE ONLY}			
			1st Visit: RN initial		2nd Visit:	
			Continue Med	Stop Med	Continue Med	Stop Med
❑ No meds taken						
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

Ambulatory Surgery Center: Patient History and Medical Information

MEDICATION ALLERGIES and REACTIONS

❑ **No known allergies** ❑ **Yes, I have an allergy to:**

	Medication/Substance/Food Allergy	Type of Reaction
1.		
2.		
3.		
4.		
5.		
6.		

MEDICAL HISTORY: Do you have or have you had any of the following? **Please circle Y or N**

I authorize the release of this information to the medical team at the ambulatory surgery center for the purposes of my care.

High Blood Pressure	Y	N	Kidney Disease	Y	N	Cancer	Y	N
Heart Attack	Y	N	Hemodialysis	Y	N	Arthritis	Y	N
Irregular Heartbeat	Y	N	Liver Problems	Y	N	Stroke	Y	N
Rheumatic Fever	Y	N	Jaundice	Y	N	Seizures	Y	N
Hepatitis B	Y	N	Hepatitis C	Y	N	AIDS or HIV	Y	N
Chest Pain	Y	N	Asthma	Y	N	Thyroid Problem	Y	N
Cardiac Pacemaker	Y	N	Wheezing	Y	N	Sinus Problems	Y	N
Reflux	Y	N	Difficulty Breathing	Y	N	Anxiety	Y	N
Heartburn	Y	N	Emphysema	Y	N	Easy Bruising	Y	N
Head Injury	Y	N	Difficulty Hearing	Y	N	Easy Bleeding	Y	N
Neck Pain	Y	N	Postnasal Drip	Y	N	Back Problem	Y	N
Migraine Headaches	Y	N	Productive Cough	Y	N	Difficulty Lying Flat	Y	N
Insulin Dependent Diabetes	Y	N	Substance Abuse	Y	N	Dizziness	Y	N
Non-Insulin Dependent Diabetes	Y	N	Marijuana Use Medical/Recreational	Y	N	**Have you ever smoked?** How much: _____ # of years: _____ Quit Date: _____	Y	N
Other:								

Patient/Guardian Signature: _____ **Date**_____

***If patient does not sign his/her own legal documents please attach legal documentation of agent*

SURGERY CENTER USE ONLY: TO BE COMPLETED ON SURGERY DAYS:

FIRST Eye Surgery:

❑ No changes to above.

❑ Changes/Additions to above: _____

Nurse Signature: _____ Date: _____

SECOND Eye Surgery:

❑ The only change to above is the previous eye surgery.

❑ Changes/Additions to above: _____

Nurse signature: _____ Date: _____

THIRD Eye Surgery:

❑ The only change to above is the previous eye surgeries.

❑ Changes/Additions to above: _____

Nurse signature: _____ Date: _____