Advanced Surgical &
Weight Loss Institute, LLC
Dr. Diego Velarde
321-549-2000

Date _____

Patient Name _____
FIRST **MIDDLE** **LAST** **AGE** **DOB** **SEX**

Address _____
STREET **APT#** **CITY** **STATE** **ZIP CODE**

Marital Status: _____ **Language:** _____ **Race:** _____

Home Phone _____**Cell Phone** _____**Email** _____

Primary Insurance: _____

Secondary Insurance: _____

Pharmacy _____**Address/Intersection**_____

Preferred Lab: (CIRCLE ONE) Quest / LABCORP / HEALTH FIRST / ORLANDO HEALTH / PCP OFFICE/ OTHER:_____

Primary Care Doctor _____ **Cardiologist** _____

Pulmonary _____ **Gastroenterology** _____

Neurology _____ **Nephrologist** _____

HIPPA Release of Information

The Notice of Privacy Practices explains in detail how your confidential health information is handled by our office. It also describes how you can exercise your rights with regard to your protected health information.

I, _____ give my permission for Advanced Surgical and Weight Loss Institute to discuss my medical care with the following persons other than myself:

Name _____ Relationship _____ Phone _____

Emergency Contact: _____ **Phone#**_____

Appointment and Surgery Cancelations

Please provide 24 hour notice if you are not going to make your office visit appointment with Dr Velarde. No-shows to appointments and cancelations within 24 hours will be subject to a charge of $49. If you need to cancel a surgery you MUST cancel the week prior to avoid a charge of $199 for General Surgery and $99 for Colonoscopy/EGD's.

Please check with your insurance to be sure we are in network with your insurance. If you do not have insurance, payments are your responsibility and will be due at/prior to time of service.

_____ _____

Patient Name **Date**

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HEALTH HISTORY QUESTIONARIE

Your Medical History

- ☐ Acid Reflux/GERD
- ☐ Arthritis
- ☐ Asthma
- ☐ Anxiety
- ☐ Cancer_____
- ☐ COPD
- ☐ Depression
- ☐ Diabetes Type____
- ☐ GI issues _____
- ☐ Heart Attack
- ☐ Heart Burn
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Pacemaker/Implanted Device
  - ○ _____
- ☐ Stroke
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Thyroid Disorder
- ☐ Other: _____

Your Family's History:

Relationship to you

- ☐ Bleeding Disorders _____
- ☐ Cancer (type) _____
  _____
- ☐ Diabetes _____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ Seizures _____
- ☐ Stroke _____
- ☐ Thyroid Disorders _____
- ☐ Other: _____

Please answer all questions completely

Do you use alcohol? YES NO _____ PER DAY WEEK MONTH

Tobacco Use YES NO
Packs/day _____ Years smoked _____ Year quit _____

History of drug abuse? YES NO

History of MRSA infection YES NO

Surgical History **Year**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Last Colonoscopy _____ Polyps Y/N
Last EGD _____ Hiatal Hernia Y/N
Last Mammogram _____ Normal/ Abnormal

Medications/Over the counter vitamins and supplements

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies to medications? LATEX YES NO

_____
_____