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

Home Phone _____________________Cell Phone ______________________Email ____

Pharmacy __________________________Address/Intersection__________________________

Primary Care Provider______________________________________

Marital Status: ____________________ Language: ___________________ Race: ______________________________

Emergency Contact: _______________________________________ Phone#____

Primary Insurance: _________________________________

Secondary Insurance: ______________________________

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 ______________________

Name ______________________________________ Relationship __________________ 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
- ☐ Stroke
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Thyroid Disorder
- ☐ Other: _____________________________

Your Family's History:

Relationship to you

- ☐ Asthma ______________
- ☐ 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

COVID Vaccinated YES NO

Surgical History	Year
____________________________________	______
____________________________________	______
____________________________________	______
____________________________________	______
____________________________________	______

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

Medications

____
____
____
____
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____
____
____
____

Allergies to medications? LATEX YES NO

____
____
____

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Advancedsurgical.md