Advanced Surgical & Weight Loss Institute, LLC

Phone: (321) 549-2000/ FAX: (321) 549-2142
Rockledge Office: 3165 Suntree Blvd, Suite 101
Rockledge, Fl 32955

West Melbourne Office: 1541 South Wickham Rd
Melbourne Fl, 32904

PATIENT ENROLLMENT FORM

PATIENT BASIC INFORMATION:

PATIENT NAME:_____
LAST FIRST MI MAIDEN OR OTHER NAME

SEX: ☐ MALE ☐ FEMALE DOB: _____/_____/_____ SS# _____--_____--_____
MO DAY YEAR

ETHNICITY: _____ MARITAL STATUS: _____

HOME ADDRESS:_____CITY_____STATE_____ZIP_____

PHONE: _____ E-MAIL: _____

☐ CELLULAR ☐ HOME ☐ WORK FAX: _____

EMERGENCY CONTACT: _____ PHONE: _____

PRIMARY EMPLOYER: _____

ADDRESS: _____CITY_____STATE_____ZIP_____

PHONE: _____E-MAIL: _____

RELATIONSHIP TO PATIENT: ☐ Parent ☐ Spouse ☐ Caregiver ☐ Friend ☐ Other _____

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

ADDRESS: _____CITY_____STATE_____ZIP_____

PHONE: _____ E-MAIL: _____

☐ CELLULAR ☐ HOME ☐ WORK

PRIMARY INSURANCE /NAME OF INSURRED: _____/_____

POLICY #_____ GROUP #_____ COPAY AMT _____

DEDUCTIBLE _____ EFECTIVE DATE _____ EXPIRATION DATE _____

ADDRESS: _____CITY_____STATE_____ZIP_____

SECONDARY INSURANCE (if applicable):

NAME OF INSURANCE: _____
POLICY# DEDUCTIBLE NAME OF INSURED

RELATIONSHIP TO PATIENT: ☐ Parent ☐ Spouse ☐ Caregiver ☐ Friend ☐ Other _____

I authorize payment directly to the billing office of this physician/clinic for the medical and / or surgical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance. Payment of deductibles and co-payments is expected at the time of service. Cash, Check, MasterCard, American Express, and Discover Cards are acceptable methods of payment. Insurance claims for each service date will be submitted to your insurance company, after which time the responsibility for payment will become yours. In the event this account is placed with a collection agency you will be responsible for collections fees and/or attorney fees.

SIGNATURE OF PATIENT / GUARDIAN:_____ **DATE**:_____.

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DOB: _____/_____/_____ SS# _____--_____--_____
MO DAY YEAR

ADDRESS:_____CITY_____STATE_____ZIP_____

PHONE:_____E-MAIL: _____

☐ CELLULAR ☐ HOME ☐ WORK

PRIMARY CARE PHYSICIAN:_____PHONE_____

I hereby authorize _____
to release information from my medical record as indicated below to:

NAME: Diego Velarde M.D

ADDRESS: 3165 Suntree Blvd, Suite 101, Rockledge, FL 32955

PHONE: (321)549-2000 FAX: (321) 549-2142

Please send only the following information: _____

INFORMATION TO BE RELEASED: I understand that documents authorized to be released by me include, but are not limited to, family histories, medical histories, reports of clinical findings and all diagnoses. Laboratory test results, X-ray results, reports of examination, and/or evaluation, and any hospital admission or discharge reports. My parental rights have not been terminated. (In the case of signing for a minor child)

_____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

PURPOSE OF THIS DISCLOSURE: ☐ Changing Physicians ☐ Consultation / 2nd Opinion

☐ Continuing Care ☐ Legal ☐ School ☐ Insurance ☐ Worker's Compensation

☐ Other / Specify: _____

1. I understand that this authorization will expire in 90 days
2. I understand that I may revoke this authorization at any time by notifying Advanced Surgical & Weight Lost Institute, LLC in writing, and it will be effective on the date notified except to the extend action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that in compliance with Florida regulations I will pay the charge for copying clinic medical records is $1 per page up to 25 pages and 15 cents for each additional page.

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PATIENT ENROLLMENT FORM

PATIENT NAME:_____
LAST FIRST MI MAIDEN/OTHER

Please read and **Initial** each line. If you have any questions, please ask the front desk for assistance.

1._____ I have given the office my current and correct insurance information. I will also update any changes in my insurance with the office.

2._____ I understand it is my responsibility to manage my appointments responsibly and I could be charged $25.00 for a missed appointment if a 24 hour notice of cancellation is not given.

3._____I understand that I could be discharged from the practice for failing to give a 24 hour cancellation notice for three or more scheduled appointments.

4._____I understand my co-pay is due at each visit.

5._____I understand there may be an administrative charge for the completion of letters and/or forms by this office.

6._____I understand that I will be charged a $25.00 fee for any bounced checks.

NOTICE: I attest that the above information is correct to the best of my knowledge. I authorize the release of any medical or other information necessary to process a claim. I also request payment of insurance benefits to myself or to the party who accepts the assignment. I authorize payment of insurance benefits to the physician or supplier for all services rendered. I also understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered or fees associated with my care. I also agree that I am responsible for any collection fees should my account be turned over to a collection agency.

SIGNATURE OF PATIENT/GUARDIAN:_____DATE:_____

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HEALTH HISTORY QUESTIONARIE

PATIENT NAME: _____ _____ _____ _____DOB: _____ _____
LAST FIRST MI

SEX: ☐ *MALE* ☐ *FEMALE*

✔LIST YOUR REASONS FOR COMING TO SEE THE DOCTOR TODAY:

_____

_____

✔PAST MEDICAL HISTORY (*Major events, hospitalizations, surgeries*)**:**

1. Diabetes ☐ Yes ☐ No
2. Hypertension ☐ Yes ☐ No
3. High Cholesterol ☐ Yes ☐ No
4. Heart Disease ☐ Yes ☐ No,
   Type: _____
5. Lung Disease ☐ Yes ☐ No,
   Type: _____
6. Kidney Disease ☐ Yes ☐ No,
   Type: _____
7. Acid Reflux ☐ Yes ☐ No,
   Type: _____
8. Sleep Apnea ☐ Yes ☐ No,
   Type:_____
9. Cancer ☐ Yes ☐ No
   Type: _____
10. Seizures ☐ Yes ☐ No
11. Stroke ☐ Yes ☐ No
12. Depression ☐ Yes ☐ No
13. Thyroid ☐ Yes ☐ No
    Disorder
14. Others

✔PAST SURGICAL HISTORY (*Major events, hospitalizations, surgeries*)**:**

1. _____.
2. _____.
3. _____.
4. _____.
5. _____.

✔ OTHER HISTORY: Date of Last Endoscopy _____

1. Date of Last Colonoscopy _____.
2. Date of Last Mammogram _____.

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ALLERGIES TO MEDICATIONS:

Drug Name	Reaction	Drug Name	Reaction

✔FAMILY HISTORY:

Diagnosis	Relation	Age at Diagnosis

✔PLEASE LIST MEDICATIONS THAT YOU TAKE. If you don't know the name just mention what medication is for. For Example "cholesterol medicine" "heart pill", etc.

_____
_____
_____
_____
_____
_____

Social History:

Occupation: _____

Have You Ever Smoked? _____

Do You Drink Alcohol? If so, how often? _____

Do You Use Illicit or recreational drugs? _____

PATIENT NAME:_____**SIGNATURE**_____

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Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of this Office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

Please list the names of anyone who the office staff may release information to on your behalf. If they are not on this list no information will be released regarding your care or condition.

NAME

_____

_____

RELATION TO PATIENT

_____

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to accept Notice.
_____ Individual refused to sign Acknowledgement.
_____ Individual was unable to sign.
_____ An emergency situation prevented us from obtaining acknowledgement.
_____ Other: _____

_____

Employee Signiature **Date**