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

PATIENT INFORMATION FORMS
PLEASE COMPLETE ALL PAGES

Date _____

How did you hear about us? _____

Patient Name _____
FIRST MIDDLE LAST AGE DOB SEX

Address _____
STREET APT# CITY STATE ZIP CODE

Home Phone _____Cell Phone _____Email _____

SS#_____ Pharmacy _____Address/Intersection_____

Primary Care Provider_____ Referred by _____

Marital Status: _____ Language: _____ Race: _____

Emergency Contact:_____ Phone#_____

Primary Insurance: _____

Policy Holder Name: _____ DOB: _____

Secondary Insurance: _____

Policy holder name: _____ DOB: _____

Your health insurance program may have limits that will affect your charges at our office. Some insurance companies will not pay for certain tests or office visits and those charges will be your responsibility. We accept assignment with numerous insurance carriers. 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.

I HAVE READ AND UNDERSTAND THE ABOVE and hereby give my consent to any physician member or designee to provide medical treatment to me encompassing diagnostic and therapeutic procedures.

_____ _____
Patient Signature Date

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

MEDICAL RECORDS RELEASE

I hereby authorize: _____to release my medical records to:

Advanced Surgical and Weight Loss Institute
3165 Suntree Blvd Suite 101
Rockledge, FL 32955
Phone 321-549-2000
Fax: 321-549-2142

Any information including diagnostic studies and medical records and/ or examinations rendered to me during the time period of _____to _____. This also includes any and all Federal and State protected information including without limitations psychiatric, drug and/or alcohol abuse and human immunodeficiency virus test results.
I understand and direct that this authorization will remain effective for 365 days or until I revoke it. I hereby release Advanced Surgical and Weight Loss Institute from any and all liability that may arise from the release of this information as I have directed.

_____ _____
Patient Name DOB

_____ _____
Patient Signature Date

_____ _____
Office Staff Signature Date

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

Please read and initial each line. If you have any questions, please see front desk.

_____ Self-pay Costs/ Deductibles/Coinsurance/Copays
Payment is due at the time of the visit. An estimated cost for services can be provided to you prior to you being seen by our physicians. Understanding that this is an Estimate and balance will be due once processed by your insurance.

_____ Participating Insurance Plans
It is the patient's responsibility to understand their insurance and seek care by an in-Network providers to avoid higher costs. In order to properly bill your insurance company and avoid untimely delays, we require that you provide us with your insurance card/ information to be kept as part of your records.
For those patients requiring a referral or authorization for service from their Primary Care Provider, please bring all the information with you to your appointment.

_____ Secondary Insurance
We will be happy to file your secondary insurance if you provide us with the necessary information. If you do not provide us with secondary insurance information, you will be responsible for filing any claims with the insurance.

Medicare: We accept assignment on all covered charges by Medicare. We will file your charges to Medicare and you're secondary. If you do not have a secondary you will be responsible for 20% of the Medicare allowable charges at the time of service, including office visits and procedures. We will be happy to provide you with an approximate cost prior to being seen by the physician**.**

_____ Payment
I understand that there will be a charge of $25.00 fee for bounced checks. Should payment be rejected, the balance plus the fee will be due.

Thank you for your understanding of this Financial Policy. Please let us know if you have any questions or concerns.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the notice.

NOTICE OF PRIVACY PRACTICES

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 _____

Name _____ Relationship _____

_____ _____
Patient Signature **Date**

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

HEALTH HISTORY QUESTIONARIE

PATIENT NAME: _____**DOB:** _____

REASON FOR VISIT: _____

Past Medical History

- ☐ Diabetes Type____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Acid Reflux/GERD
- ☐ Heart Burn
- ☐ Heart Attack
- ☐ Stroke
- ☐ Heart Disease
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ COPD
- ☐ Seizures
- ☐ Kidney Disease
- ☐ Depression
- ☐ Anxiety
- ☐ Thyroid Disorder
- ☐ Osteoarthritis _____
- ☐ Cancer _____
- ☐ Other: _____

Family History: **Relation**

- ☐ Anesthesia complications _____
- ☐ Asthma _____
- ☐ Bleeding problems _____
- ☐ Cancer (type) _____
  _____
- ☐ Diabetes _____
- ☐ Hearing Loss _____
- ☐ Heart Disease _____
- ☐ Seizures _____
- ☐ Stroke _____
- ☐ Thyroid Disorders _____
- ☐ Other: _____

Please answer all questions completely

HABITS/SOCIAL HISTORY

Do you use alcohol? YES NO
Amount/day_____

Do you smoke/chew tobacco or have in the past? YES NO
Packs/day _____ **Years smoked** _____ **Year quit** _____

History of drug abuse? YES NO

Latex Allergy YES NO

History of MRSA infection YES NO

Surgical History **Year**

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

Last Colonoscopy _____
Last EGD _____
Last Mammogram _____

Medications

_____
_____
_____
_____

Allergies

_____
_____
_____