GENERAL AND LAPAROSCOPIC SURGICAL ASSOCIATES, P.C.

STEFANO F. AGOLINI, M.D

4660 Kenmore Avenue, Suite 608
Alexandria, VA 22304

Phone: (703)823-4066
Fax: (703)823-4067

PATIENT INFORMATION

Name: ____ ***DOB:*** __________________ ***Date:*** ____________

Address: ____ City____________________State________Zip__________

Phone (______)___________________ Email Address______________________________________

Marital Status: Married _______ Single ________ Divorced ___________ Widow _________

Emergency Contact ______________________________ Relationship:_____________________________

Emergency Contact Phone: (_______)________________________

Insurance Company: ______________________________________ ID: ____________________ Group:__________________

Policy Holder __________________________________ DOB: _______________________________________

Primary Care Doctor ____________________________ Referring Doctor ____________________________________

Pharmacy Name :____ Phone: _____________________

MEDICAL HISTORY

What brings you here today: ____

Location(please specify if right or left) ____

Duration of symptoms ________________________

Any medical conditions such as:

Hypertension YES ____ NO_____

Heart Attack YES ____ NO_____

History of blood clot or pulmonary embolism YES ____ NO_____

Diabetes YES ____ NO_____

Stroke YES ____ NO_____

High cholesterol YES ____ NO_____

Any other medical conditions:

List any surgeries(especially important any abdominal or pelvic surgeries)

____

____

____

MEDICAL HISTORY CONTINUED

List of all medications you take with dose and frequency:

____

____

____

____

Do you take any blood thinners YES ____ NO_____

Are you taking any GLP-1 Medication YES____ NO____

List any allergies:

____

____

Are you at risk of falling: YES_____ NO_____

Do you smoke cigarettes YES ____ NO_____
If so when did you start and how much _______________________________

Do you drink alcohol YES ____ NO_____
If so on average how many drinks a week _____________________________

What kind of work do you do: ____

If over age of 65, do you have a living will: YES ____ NO_____
Do you have a Medical Power of attorney: YES______ NO_______
Do you have any food insecurities: YES _________ NO_______
Are you in need of shelter: YES______NO________
Do you feel safe at home: YES_______NO_______
Do you have any transportations needs YES_______ NO_______

Any family history:

____

____

List any imaging studies you have related to current problem

____

____

Anything else that you think Dr Agolini should know:

____

____

____

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Cancellation Policy/ For Surgery

- **Cancellation/ No Show Policy for Surgery**

  Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office. If surgery is not canceled at least **15 DAYS** in advance you will be charged a **$250.00** fee; this will be added as a charge to your account and will not be covered by your insurance company.

  This fee must be paid to General and Laparoscopic Surgical Associates

- **Account balances**

  We will require that patients with self pay balances or insurance copays do pay their account balances to zero (0). Patients who have questions about their bills may call our billing office representative at 888-665-8898 with whom they can review their account and concerns.

______________________	______________________	____/____/____
Print Patient Name	Signature Patient/Guardian	Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form you acknowledge that Dr. Agolini's office has given you a chance to review its Privacy Notice, which explains how health information will be handled in various situations. We must try to have you sign this form on your first date of service with us after April 14, 2003.

If your first date of service with us was due to an emergency, we must try to give you notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Check all that are true:

[ ] I have had a chance to review Dr. Agolini's Privacy Notice.
[ ] Dr. Agolini or his staff has given me the chance to discuss my concerns and questions about the privacy of my health information.

____________________________ ________________________

Patient's Signature Date

Does the patient have a copy of Privacy Notice?
[ ]Yes [ ]No

Dr. Agolini's staff should complete if Acknowledgement Form is not signed:
Please explain why the patient was unable to sign an acknowledgement form and Dr. Agolini's staff efforts in trying to obtain the patient's signature.

AI use in healthcare documentation

At **GENERAL & LAPAROSCOPIC SURGICAL ASSOCIATES** we use Athena's AI scribe to support medical documentation. This tool helps transcribe conversations, summarize clinical notes, and assist with administrative tasks. It is designed to enhance efficiency and accuracy while allowing healthcare providers to focus on patient care. However, Athena's AI scribe does not replace human medical expertise or clinical judgment. All AI-generated notes are reviewed by a licensed healthcare provider before being added to your medical record. Athena's AI tools are intended solely for documentation and administrative support and are not used to diagnose, treat, or make medical decisions.

____________________________ ________________________

Patient's Signature Date