ROBOTIC GENERAL SURGEONS

4207 James Casey St, Suite 111, Austin, TX 78745
Tel: (512) 541-2755 | Fax: (512) 541-4154

Maria Iliakova, MD, MBA, MSC, FACS | Sudeep Burman, DO

NEW PATIENT PACKET

Please complete all sections before your appointment.

This packet contains the following forms:

1. Medical History & Intake Form
2. HIPAA Acknowledgment
3. Notice of Privacy Practices
4. Consent to Treat & Communication Authorization
5. No-Show & Cancellation Policy

Last Updated: 08/18/2026

FORM 1 OF 5 | Medical History & Intake Form

Patient Demographics

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Preferred Name (if different): _____ **Date of Birth:** _____

Sex:
☐ Male ☐ Female ☐ Other / Prefer to self-describe: _____

Pronouns:
☐ She/Her ☐ He/Him ☐ They/Them ☐ Other: _____

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Social Security Number (optional): _____

☐ *I decline to provide my Social Security Number*

Race (check all that apply):
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian / Pacific Islander ☐ White ☐ Other: _____
☐ Decline to answer

Ethnicity:
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

Phone Number: _____ **Email Address:** _____

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Preferred Language: _____ **Emergency Contact Name:** _____

Relationship to Emergency Contact: _____ **Emergency Contact Phone:** _____

Primary Care Provider (if applicable): _____ **Referring Provider (if applicable):** _____

Insurance Information

Primary Insurance

Insurance Company Name: _____ **Policy / Member ID #:** _____

Group #: _____ **Policy Holder Name:** _____ **Relationship to Patient:** _____

Guarantor Name (if different from patient): _____ **Guarantor DOB:** _____ **Guarantor Phone:** _____

Secondary Insurance (if applicable)

Insurance Company Name: _____ **Policy / Member ID #:** _____

Group #: _____ **Policy Holder Name:** _____ **Relationship to Patient:** _____

Guarantor Name (if different from patient): _____ **Guarantor DOB:** _____ **Guarantor Phone:** _____

Reason for Visit

Please briefly describe the reason for your visit today:

_____

_____

Current Symptoms (check all that apply):

☐ Pain ☐ Swelling ☐ Nausea / Vomiting ☐ Fever / Chills

☐ Hernia / Bulge ☐ Changes in bowel habits ☐ Reflux / Heartburn ☐ Loss of appetite

Other symptoms: _____

Duration of symptoms: _____

Medical History

Past Medical History (check all that apply):

☐ High blood pressure ☐ Diabetes ☐ Heart disease

☐ Lung disease ☐ Asthma ☐ Sleep apnea

☐ Kidney disease ☐ Liver disease ☐ Cancer - type: _____

Other conditions: _____

Past Surgical History (procedure and year):

_____

_____

Current Medications (include dosage):

_____

_____

Pharmacy Information

Please provide your preferred pharmacy so we can send prescriptions electronically.

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Allergies:
☐ No known allergies
If yes - list medication/food and reaction:

_____

Social History

Do you smoke or use tobacco products?
☐ No ☐ Yes ☐ Former smoker
Do you drink alcohol?
☐ No ☐ Yes ☐ Occasionally
Are you currently pregnant (if applicable)?
☐ No ☐ Yes ☐ Unsure

Prior Testing / Treatment

Have you had any prior testing or treatment related to this visit? (check all that apply)
☐ Imaging (CT / MRI / Ultrasound) ☐ Lab work ☐ Emergency Room visit
☐ Prior surgery ☐ None
If yes, please explain:

_____

Patient Signature: **Date:** _____

_____

FORM 2 OF 5 | HIPAA Acknowledgment

I acknowledge that I have been informed of my rights under the Health Insurance Portability and Accountability Act (HIPAA).

I understand that the Notice of Privacy Practices describes how my protected health information (PHI) may be used and disclosed, and that a copy is available upon request at any time.

I understand that by signing below I am confirming I have been given the opportunity to review my HIPAA rights.

Patient Signature: **Date:** _____

_____

FORM 3 OF 5 | Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please read it carefully. Effective Date: 02/03/2026

Our Responsibilities

Robotic General Surgeons is required by law to maintain the privacy and security of your protected health information (PHI). We must provide you with this Notice of Privacy Practices, follow the duties described within it, and will not use or share your information in any other way unless you authorize us to do so in writing.

How We May Use and Disclose Your Health Information

Treatment: We may use and share your health information to provide, coordinate, or manage your healthcare and related services.

Payment: We may use and share your information to bill and collect payment from health plans or other entities.

Health Care Operations: We may use and share your information for practice operations such as quality assessment, staff training, and administrative activities.

Other Permitted Uses: As required by law; for public health or oversight activities; for law enforcement purposes; or to avert a serious threat to health or safety.

Your Rights

You have the right to: obtain a copy of your medical record; request corrections to your record; request confidential communications; ask us to limit how we use or share your information; receive a list of disclosures we have made; get a copy of this notice; designate a personal representative to act on your behalf; and file a complaint if you believe your privacy rights have been violated.

To file a complaint, contact our Privacy Officer (see below) or the U.S. Department of Health and Human Services. You will not face any retaliation for filing a complaint.

Changes to This Notice

We reserve the right to update this notice at any time. The most current version will be available upon request and on our website when available.

Contact - Practice Privacy Officer

Amanda Garcia | 4207 James Casey St, Suite 111, Austin, TX 78745 | Phone: (512) 541-2755

Acknowledgment of Receipt

By signing below I confirm that I have received a copy of this Notice of Privacy Practices and understand how my health information may be used and disclosed.

Patient Name (print): _____

Patient Signature: **Date:** _____

_____

If patient declines to sign: ☐ Patient declined to sign acknowledgment Staff Initials: _____ Date: _____

FORM 4 OF 5 | Consent to Treat & Communication Authorization

Consent to Treatment

I hereby consent to medical evaluation, treatment, and any surgeries or procedures deemed necessary by the provider(s) of this practice. I understand that treatment outcomes cannot be guaranteed and that the risks and benefits of any proposed treatment will be explained to me before I am asked to agree to it.

Communication Authorization

I authorize Robotic General Surgeons to contact me regarding my care using the methods checked below. I understand that electronic communications (email, text) may not always be fully secure.

☐ Phone ☐ Voicemail ☐ Email ☐ Text Message

Patient Signature: **Date:** _____

_____

FORM 5 OF 5 | No-Show & Cancellation Policy

At Robotic General Surgeons, appointment times are reserved specifically for you. To respect the time of our providers and other patients, the following policy applies:

A $50 fee will be charged for any appointment canceled or rescheduled **with less than 24 hours' notice**, or for missed appointments without prior notice.

This fee is not billable to insurance and is the patient's sole financial responsibility. It is due at or before your next appointment.

We understand that unexpected situations arise. If you need to reschedule, please contact us as soon as possible so we can accommodate you and offer your time to another patient.

By signing below, I acknowledge that I have read and understood this policy.

Patient Signature: **Date:** _____

_____