



Aaron L. Cernero, D.O.
General Surgery

Date _____ Age _____ Date of Birth _____ Pharmacy Name _____

Patient Name _____ Middle Initial _____ Social Sec. Number _____

Patient Address _____ City _____ St. _____ Zip Code _____

Home Number _____ Work Number _____ Cell Number _____

Email Address _____

Please Check Male _____ Female _____
Please Check Married _____ Single _____ Widow _____ Divorced _____
Please Check Black _____ White _____ Latino/Hispanic _____ Other _____

Patient Employer _____ Address _____ Phone Number _____

Spouse Employer _____ Address _____ Phone Number _____

Do you have any Drug Allergies? _____ If so, what reaction did it cause _____

Are you currently taking **BLOOD THINNERS**? _____

Reason for your visit _____

Who is your Primary Care Physician? _____

How did you first hear about us? TV Radio Newspaper Yellow pages Internet

Billboard Friend: _____ Dr. _____

Primary Insurance Company _____ Address _____

Policy/Group# _____

Name of Policy Holder and Date of Birth _____

Secondary Insurance Company _____ Address _____

Policy/Group# _____

Name of Policy Holder and Date of Birth _____

PLEASE READ AND SIGN BELOW LIFETIME ASSIGNMENT OF BENEFITS

I understand that I am financially responsible for all charges whether or not paid by the insurance company. I hereby authorize said assignee to release all information necessary and required to process my insurance claim to secure payment of same.

Sign _____ Date _____

Name _____

Date _____

Allergies:

- Latex Iodine
- Egg Peanuts
- No Allergy to the above list

Smoking History: _____

Alcohol History: _____

Pregnancies: _____

Live Births: _____

Past Medical History

- | | | |
|--|--|--|
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Hyperlipidemia |
| <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Polio | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> GERD |
| <input type="checkbox"/> Gout | <input type="checkbox"/> HIV | <input type="checkbox"/> PUD |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Crohn's Disease |
| <input type="checkbox"/> Upper GI Bleeding | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hiatal Hernia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> IBS |
| <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Renal Disorder | <input type="checkbox"/> COPD | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> History of biopsy | <input type="checkbox"/> Prior MI | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Cancer, Type _____ | | |

Other _____

Surgical History

Family Medical History

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Lipid Disorder | <input type="checkbox"/> Varicose Veins/Phlebitis |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Stroke | <input type="checkbox"/> Difficulty Swallowing | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Gallbladder Disease |
| <input type="checkbox"/> Peptic Ulcer | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Abdominal Pain-Chronic |
| <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Crohn's/Colitis | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Persistent Nausea |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Bloody or tarry stools | | <input type="checkbox"/> Cancer, Type _____ |

Other _____

Medications Currently Taking (PLEASE LIST MG & HOW OFTEN YOU TAKE IT)

PATIENT QUESTIONNAIRE

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations).

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Please print the address of where you would like correspondence from our office to be sent **IF** other than your home.

Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL": YES _____ NO _____

Please print the telephone number where you want to receive calls about your appointments, lab & X-Ray results, other health care information **IF** other than your home phone number: () _____.

****I am fully aware that a cell phone is not a secure and private line.***

Can confidential messages be left on your telephone answering machine? YES _____ NO _____

I am fully aware my health information will be transmitted by electronic transmission, by fax transmittal, by internet or by e-mail.

PATIENT SIGNATURE: _____ DATE _____

(guardian if under 18 years of age)

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to changes their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

**SIGNATURE OF PATIENT,
PARENT OR LEGAL GUARDIAN**

DATE

Medication List Consent

By signing this consent form you are agreeing that your provider at Cernero Surgery may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

This consent will remain in effect until the day you revoke consent in writing with our office.

**SIGNATURE OF PATIENT,
PARENT OR LEGAL GUARDIAN**

DATE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Aaron L. Cernero, D.O.
5012 South Highway 75 Suite 205 Denison, TX 75020
Phone # 903-462-4247 Fax # 903-462-4248

Patient's Name _____ Date: _____

Address _____ Date of Birth: _____

Receive Records From:

Release Records To:

Please send a copy of my records as indicated for date(s) of Treatment: _____

_____ Operative Records _____ Lab Reports _____ H&P

_____ X-Ray Reports _____ Discharge Summary _____ other

Purpose for releasing medical information

**SIGNATURE OF PATIENT,
PARENT OR LEGAL GUARDIAN**

DATE

I understand that my express consent is required to release any health information any health information relating to testing, diagnosis and/or treatment of alcohol or drug related medical problems, and this special consent also will apply to HIV/AIDS related diagnosis, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42C.F.R. Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith.

I understand that I may revoke this authorization at any time by notifying the office in writing.