Cernero Surgery & Aesthetics
GENERAL & BARIATRIC SURGERY

Aaron L. Cernero D.O.
General Surgery

Date_____ Age_____ Date of Birth _____ Pharmacy Name/City_____

First, Middle, Last Name_____

Address_____ City _____ St. _____ Zip Code_____

Home Number _____ Work Number _____ Cell Number _____

Email Address _____ Social Sec. Number_____

Please Circle: Male Female Unknown

Please Circle: Married Single Widow Divorced Partner Unknown

Please Circle: Black White Latino/Hispanic Other, Please specify _____ Declined to Specify

Patient Employer _____ Address _____ Phone Number _____

Spouse Employer _____ Address _____ Phone Number _____

Do you have any Drug Allergies? _____
If YES, 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? ( ) Facebook ( ) Instagram ( ) Google ( ) TV ( ) Internet

( ) 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 _____

Smoking History: Current Smoker – Vaping Yes / No
How much per day: _____
Former Smoker Yes / No
How many Years: _____
When did you stop:____
Never Smoker Yes / No

Allergies:
□Latex □ Iodine
□ Egg □ Peanuts
□ No Allergy to the above list

Pregnancies: _____
Live Births: _____

Alcohol History: Did you have a drink of alcohol in the past year Yes/No
If YES: How often Monthly – Weekly – Daily
How many drinks a day: _____
How often did you have 6 or more drinks in a day in the past year: _____

Past Medical History

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

Other_____
_____

Surgical History

_____

_____

Family Medical History

___ Epilepsy
___ Migraine
___ Asthma
___ Anemia
___ Diabetes
___ Peptic Ulcer
___ Diverticulosis
___ Heartburn
___ Thyroid Disease
___ Arthritis
___ Heart Disease
___ Stroke
___ Hypertension
___ Diarrhea
___Crohn's/Colitis
___ Bloody or tarry stools
___ Lipid Disorder
___ Loss of Appetite
___ Hepatitis/Jaundice
___ Difficulty Swallowing
___ Hemorrhoids
___ Constipation
___ Vomiting
___Varicose Veins/Phlebitis
___ Hernia
___ Glaucoma
___ Gallbladder Disease
___ Abdominal Pain-Chronic
___ Persistent Nausea
___Cancer, Type _____

Other_____
_____

Medications Currently Taking (PLEASE LIST DOSAGE & 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 Aaron L. Cernero D.O. 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 # 888-212-0812

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.