Cernero Surgery & Aesthetics
GENERAL & BARIATRIC SURGERY

Please have your paperwork complete by your appointment time.

(PLEASE PRINT LEGIBLY, add as much detail as possible and use BLACK OR DARK BLUE INK.)

PLEASE LIST YOUR FULL LEGAL NAME **TODAY'S DATE:**

PLEASE ENTER YOUR CONTACT INFORMATION		
LAST:	**FIRST:**	**MIDDLE:**
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:

DOB:	AGE:	SSN:	GENDER: ☐ F ☐ M
1ST Choice Contact #	☐ Home ☐ Mobile ☐ Work		
2nd Choice Contact #	☐ Home ☐ Mobile ☐ Work		
EMAIL:			
MARITAL STATUS: ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Other_____			
ETHNICITY: ☐ Hispanic/Latino Origin ☐ Non-Hispanic/Non-Latino Origin			
RACE: ☐ Asian ☐ Black ☐ American Indian/Alaska Native ☐ Pacific Islander ☐ White ☐ Other			
EMPLOYER:		OCCUPATION:	
PRIMARY CARE PHYSICIAN:		PHONE#:	
REFERRING DOCTOR:		PHONE#:	

**** For patients who intend to self-pay, please note that in the box below and do not complete the insurance information. This will help to avoid delays in processing your application. ****

PRIMARY INSURANCE PLAN:

NAME OF INSURED:	INSURED'S DOB:
RELATIONSHIP:	SSN if other than patient):
EMPLOYER NAME:	

SECONDARY INSURANCE PLAN:

NAME OF INSURED:	INSURED'S DOB:
RELATIONSHIP:	SSN (if other than patient):

TELL US HOW YOU HEARD ABOUT OUR PRACTICE

☐ Internet/Cernero Surgery Website ☐ PCP/Referring Doctor ☐ Friend / Family Member
☐ TV/Radio/Magazine ☐ Insurance Company ☐ Social Media/Facebook/Instagram
☐ Current Patient, if so, who?

ARE YOU ALLERGIC TO ANY MEDICATIONS: ☐ Yes ☐ No

Medications/Reactions:

Medications/Reactions:

☐ Latex ☐ Iodine ☐ Eggs ☐ Peanuts ☐ Other:

ARE YOU TAKING ANY BLOOD THINNERS: ☐ Yes ☐ No Prescribing Physician:

PATIENT NAME:	DOB:

PHARMACY NAME:		PHARMACY PHONE:	

NOT TAKING MEDICATIONS: ☐ YES ☐ NO

MEDICATION NAME/STRENGTH	DOSE	PURPOSE	DATE STARTED	DATE STOPPED
EXAMPLE: SAMPLE 200mg	Once a day	Blood Pressure	May 2019	May 2022
OTHER OTC MEDICATIONS:				

Do you take antacids? (please check all that apply) **Date Started:**

☐Maalox ☐Mylanta ☐Tums ☐Rolaids ☐Pepto-Bismol ☐Pepcid (famotidine) ☐Zantac (ranitidine) ☐Tagamet (cimetidine) ☐Prilosec (omeprazole) ☐Aciphex (rabeprazole)RX ☐Nexium (esomeprazole)RX ☐Prevacid (lansoprazole)RX ☐Protonix (pantoprazole)RX Other:_____

Vitamin/Mineral Supplements: (please check all that apply):
☐ Never ☐ Occasionally ☐ Daily

☐ Multi Vitamin ☐ Vitamin D ☐ Vitamin B-12 (weekly) Other: _____

Do you have anemia: ☐ YES ☐ NO
IRON supplementation ☐ YES ☐ NO
Date Started:_____
How often: _____

Do you take OTC Pain relievers? (please check all that apply): ☐ YES ☐ NO **Date Started:**_____
☐Acetaminophen (Tylenol) ☐Ibuprofen (Motrin, Advil) ☐Naproxen (Aleve, Naprosyn)
☐Aspirin OTHER: _____

CPAP/BIPAP: ☐ Never ☐ Occasionally ☐ Every Night

DATE UPDATED:		PATIENT INITIALS:		DATE UPDATED:		PATIENT INITIALS:	
DATE UPDATED:		PATIENT INITIALS:		DATE UPDATED:		PATIENT INITIALS:	
DATE UPDATED:		PATIENT INITIALS:		DATE UPDATED:		PATIENT INITIALS:	

PATIENT NAME: **DOB:**

PATIENT HEALTH AND WELLNESS INFORMATION

(Please ☑ all that apply to you the patient)

Problem/Symptom	Y	N	Year	Diagnosing Physician	Problem/Symptom	Y	N	Year	Diagnosing Physician
Anorexia	☐	☐			Hepatitis A/B/C	☐	☐		
Arthritis	☐	☐			Hernia	☐	☐		
Asthma	☐	☐			High Cholesterol	☐	☐		
Autoimmune Disease	☐	☐			History of Biopsy	☐	☐		
BiPAP	☐	☐			HIV	☐	☐		
Bipolar Disorder	☐	☐			Hyperlipidemia	☐	☐		
Bleeding Disorder	☐	☐			Hypertension	☐	☐		
Blood Disorder	☐	☐			IBS	☐	☐		
Bronchitis	☐	☐			Indigestion/Heartburn	☐	☐		
Bulimia	☐	☐			Liver Disease	☐	☐		
Cancer	☐	☐			Migraine Headaches	☐	☐		
Chest Pain	☐	☐			Multiple Sclerosis	☐	☐		
Chronic Fatigue	☐	☐			Palpitations	☐	☐		
Cirrhosis	☐	☐			Peptic Ulcer Disease	☐	☐		
Colitis	☐	☐			Polio	☐	☐		
Congestive Heart Failure	☐	☐			Pregnancies	☐	☐		
Constipation	☐	☐			Prior MI	☐	☐		
COPD/Emphysema	☐	☐			Prostate Problems	☐	☐		
CPAP	☐	☐			Pulmonary Embolism	☐	☐		
Crohn's Disease	☐	☐			Peptic Ulcer Disease	☐	☐		
Degenerative Joint	☐	☐			Renal Disorder	☐	☐		
Depression	☐	☐			Schizophrenia	☐	☐		
Diabetes	☐	☐			Shortness of Breath	☐	☐		
Edema/Swelling	☐	☐			Sleep Apnea Syndrome	☐	☐		
Fibrocystic Breast Disease	☐	☐			Snoring	☐	☐		
Fibromyalgia	☐	☐			Stroke	☐	☐		
Gastroesophageal Reflux	☐	☐			Thyroid Disease	☐	☐		
Gout	☐	☐			Tuberculosis	☐	☐		
Heart Attack	☐	☐			Ulcerative Colitis	☐	☐		
Heart Disease	☐	☐			Upper GI Bleeding	☐	☐		
Heart Valve Replacement	☐	☐			Urinary Incontinence	☐	☐		
Other:									

FAMILY MEDICAL HISTORY

(Please ☑ all that apply to the patient's family members)

Problem/Symptom	Y	N	Family Member	Problem/Symptom	Y	N	Family Member
Anemia	☐	☐		Stroke	☐	☐	
Autoimmune Disease	☐	☐		Thyroid Disease	☐	☐	
Bleeding Disorder	☐	☐		Breast Cancer	☐	☐	
Crohn's Disease	☐	☐		Colon Cancer	☐	☐	
Diabetes	☐	☐		Liver Cancer	☐	☐	
Diverticulosis	☐	☐		Melanoma Cancer	☐	☐	
Gallbladder Disease	☐	☐		Pancreatic Cancer	☐	☐	
Heart Disease	☐	☐		Pancreatic Cancer	☐	☐	
Hypertension	☐	☐		Stomach Cancer	☐	☐	
Lipid Disorder	☐	☐		Uterine Cancer	☐	☐	
Peptic Ulcer	☐	☐		Other:	☐	☐	

PATIENT NAME:	DOB:

SURGICAL HISTORY			
(Please ☑ all that apply to you the patient)			
☐ Esophagus Surgery	Year:	☐ Stomach Surgery	Year:
☐ Hernia Repair	Year:	☐ Caesarian Surgery	Year:
☐ Abdominal Hysterectomy	Year:	☐ Other Surgery	Year:
☐ Other Surgeries:			
☐ Malignant Hyperthermia – severe reaction to certain drugs used for anesthesia			

SOCIAL HISTORY
Tobacco: ☐Never ☐Rarely ☐Occasionally ☐Frequently ☐Quit (Month/Year): ☐Started (Month/Year):
Alcohol: (over the last 12 months) ☐Never ☐Rarely ☐Occasionally ☐Frequently
Marijuana: (over the last 12 months) ☐Never ☐Rarely ☐Occasionally ☐Frequently
Have you ever used Drugs (over last 12 months - other than those for medical reasons): ☐ Yes ☐ No **List the type of drug/s:** ☐Never ☐Rarely ☐Occasionally ☐Frequently

HIPPA PATIENT CONSENT FORM REGARDING PHI

I understand that as part of my healthcare, **Aaron L. Cernero D.O., P.A.** originates and maintains health records that may describe my health history, symptoms, examination and test results, diagnoses, treatment and/or plans for future care.

Notice of Privacy Practices of **Aaron L. Cernero D.O., P.A.** provides specific information and description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review this prior to signing this consent.

I further understand that any and all records, whether written, oral or in electronic formation, are confidential and cannot be disclosed without my prior consent, except as otherwise provided by law.

Listed below are individuals to whom I **authorized** use and/or disclosure of my PHI.

NAME	RELATIONSHIP	PHONE	EMERGENCY CONTACT	GUARDIAN
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

I requested the following **restrictions** on the use and/or disclosure of my personal health information.

Print Name and Signature of Patient or Legal Representative Date

Cernero Surgery & Aesthetics
GENERAL & BARIATRIC SURGERY

AARON L. CERNERO D.O., P.A.

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMAITON

How We May Use and Disclose Your Health Information

Your protected health information will be used by Aaron L. Cernero D.O., P.A., or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

The Notice of Privacy Practices

Aaron L. Cernero D.O., P.A., is required to provide you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" brochure provided to you.

You May Place Restrictions on the Use or Disclosure of Your Health Information

You may request a restriction on the use or disclosure of your protected health information. However, Aaron L. Cernero D.O., P.A., may or may not agree to your request to restrict the use or disclosure of your protected health information. You may be asked to complete an authorization to activate this request. Please consult with a practice representative if you would like additional information or clarification. It is a violation of the federal privacy standards if Aaron L. Cernero D.O., P.A., agrees and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information before the date of your request. If you still have questions after reviewing the Notice of Privacy Brochure, please consult with a practice representative at the location and contact information listed on the back of the brochure.

Email and Texting Informed Consent

I acknowledge that I have read and fully understand the Email and Texting Informed consent form. I understand the risks associated with the communication of cell phones, email and/or texts between Dr. Cernero and myself, and consent to the conditions and instructions outlined, as well as any other instructions that Dr. Cernero may impose to communicate with me by email or text. By signing this form, I authorize the provider to send text messages to my cell phone regarding scheduling and treatment. I understand that standard text messaging rates will apply to any messages received. I also understand that I or Dr. Cernero may revoke this permission in writing at any time. I agree not to hold the provider liable for any electronic messaging charges or fees generated by this service. I further agree that in the event my cell phone number and or cell provider changes I will inform Dr. Cernero's office.

You May Revoke This Consent at Any Time

You may revoke this consent at any time; however, Aaron L. Cernero D.O., P.A., requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect use and disclosure of your information before the date of your request.

Changes to Privacy Practices

Aaron L. Cernero D.O., P.A., reserves the right to change or modify the privacy practices outlined in the Notice of Privacy Brochure. Aaron L. Cernero D.O., P.A. will notify you of any changes of privacy practices at your next appointment or another pre-approved method that you request.

Pharmacy History

I give Aaron L. Cernero D.O., P.A., permission to view my prescription history from external sources.

Signature

I have reviewed this consent form, received the brochure entitled "Notice of Privacy Policies and Practices" and "Email and Texting Informed Consent Form" and give my permission to Aaron L. Cernero D.O., P.A., to use and disclose my health information in accordance with this consent and the notice provided.

Print Name and Signature of Patient or Legal Representative Date of Birth Today's Date

Aaron L. Cernero D.O., P.A.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

5012 SOUTH US HIGHTWAY 75, STE 250
DENISON, TX. 75020
PHONE (903) 462-4247 FAX (888) 212-0812

Patient Name _____ Date Of Birth _____
Phone Number _____ Last 4 Of SSN _____

Above listed patient authorizes Aaron L. Cernero D.O., P.A. to make records disclosure to and receive records from the following healthcare providers or facilities:

PLEASE LIST ANY DOCTORS YOU'VE SEEN IN THE LAST 5 YEARS:

Physician Name (First & Last)/ Specialty	Phone Number	Fax Number
Physician Name (First & Last)/ Specialty	Phone Number	Fax Number
Physician Name (First & Last)/ Specialty	Phone Number	Fax Number
Physician Name (First & Last)/ Specialty	Phone Number	Fax Number
Physician Name (First & Last)/ Specialty	Phone Number	Fax Number

DATES AND TYPE OF INFORMATION TO DISCLOSE:

- Please send 1 visit note with the patient's **HEIGHT** and **WEIGHT** from **each year that the patient was seen in your office**, or **for the past 5 years**
- Entire medical record for the past 2 years
- Entire medical record for the past 5 years
- Specific Information Requested:_____

THE PURPOSE OF DISCLOSURE:

- Medical Care
- Consideration For Surgery

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____ I authorize this information to be disclosed to/from Aaron L. Cernero D.O., P.A.

_____ I do not authorize this information to be disclosed to/from Aaron L. Cernero D.O., P.A.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
This authorization will expire on the date:_____. If no expiration date is specified, this authorization will expire 1 year from the date signed.

Signature of Patient/Parent/Guardian or Authorized Representative Date

Printed Name of Authorized Representative Relationship to Patient