

Patient Information (Confidential)

MRN # _____

Name _____ Home Phone _____
(First) (Middle) (Last) (Goes By/Nickname)

Address _____ Apt/Lot # _____

City _____ State _____ Zip _____ Cell Phone _____

Date of Birth _____ Age _____ SS # _____ Sex: Male Female

Employer _____ Work Phone _____ Ext. _____

Check Appropriate Box: Single Married Divorced Widowed

Language: English Spanish Chinese French German Japanese Korean Vietnamese Other _____

Race: American Indian or Alaska Native Asian Black or African American Hispanic Native Hawaiian or Other Pacific Islander White

Ethnicity: Hispanic or Latino Non-Hispanic or Non-Latino

Preferred method of communication for receiving a Clinical Summary: Print Save to File Patient Portal (when ready)

Preferred method of communication for receiving appointment reminder: Home PH Work PH Cell PH Mail Patient Portal (when ready)

Email address: _____ Referral Source: (friend, newspaper, tv..) _____

If Student, Name of School/College _____ Full Time Part Time

Primary Care Physician _____ Referring Physician _____

Emergency Contact(s): Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Person Financially Responsible (Guarantor)

Person Responsible for Account _____ Relationship to Patient _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Date of Birth _____ SS # _____ Sex: Male Female

Employer _____ Work Phone _____ Power of Attorney _____

If Patient is Under 18 years old:

Mother's Full Name _____ Employer _____ Work Phone _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Date of Birth _____ SS # _____

Father's Full Name _____ Employer _____ Work Phone _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Date of Birth _____ SS # _____

Insurance Information (check all that apply) Please provide card for receptionist to copy

Primary Secondary Tertiary Workers Compensation Other

Insurance Name:					
Effective Date:					
Subscriber Name:					
Subscriber DOB:					
Subscriber Employer:					
Relation to Patient:					

Authorization for the release of medical information and assignment of benefits

I authorize the release of my medical records from Cornerstone Healthcare, P.A. in order to process any claims. I authorize you to release copies of my medical records including current and previous records from other medical facilities to other offices which are a part of Cornerstone Healthcare, P.A. I hereby authorize payment directly to this medical association for the medical care and/or surgical benefits that is entitled to under my insurance plans. I understand that as the patient (or the patient's parent/guardian) I am responsible for any unpaid balance on this account. I also understand that if any charges are not covered by insurance, workers' compensation or other third party payers, I am responsible for full payment. I understand that fees for visits, examinations or treatments are payable at the time of service unless covered by insurance or arrangements have been made in advance. Fees for special medical reports are payable in advance. Charges for accidental injury are payable at the time of service, regardless of any pending litigation or settlement. All telephone numbers provided by you may be subject to receiving calls from an automated dialer using a pre-recorded, artificial voice message or live operator call. You give your prior express consent to receive such phone calls, including any calls made to your provided cellular telephone number.

Signature: _____ Date: _____

Patient/Parent/Person Financially Responsible

____ Acct Updtd ____ Pat Updtd ____ Ins Updtd ____ Comments Updtd ____ Scanned