CORNERSTONE health care

Thank you for selecting our Cornerstone family.
If you have any questions or need assistance, we will be happy to help.

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 Rev 06/2010

Welcome