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._____

Employer Address ____

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 ☐ Multi-Racial or Other

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

Collecting race, ethnicity, and language data using standard categories helps us make sure that everyone is receiving the same high-quality care.

Preferred method of communication for receiving a Clinical Summary: ☐ Print ☐ Save to File ☐ Patient Portal

Preferred method of communication for receiving appointment reminder: ☐ Home PH ☐ Cell PH ☐ Patient Portal ☐ Mail ☐ Text Message

Preferred method of communication for receiving health management reminders: ☐ Home PH ☐ Cell PH ☐ Patient Portal ☐ Mail ☐ Text Message

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

Insurance Name:	Primary	Secondary	Tertiary	Workers Compensation	Other
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 by Cornerstone Health Care, PA; for medical claims in agreement with the notice of Privacy Practices. I am **responsible for any unpaid balance on my account(s).** I understand that fees for visits, examinations, or treatments are **payable at 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 time of service, regardless of any pending litigation or settlement. All telephone numbers, text messaging and email addresses may be subject to receiving calls and written messages from an automated delivery system. Your signature authorizes consent and permission to contact you via internet and other telecommunication devices.

Signature:____ Date: __________________
Patient/Parent/Person Financially Responsible

_____Acct Updtd _____Pat Updtd _____Ins Updtd _____Comments Updtd _____Scanned Rev 02/15

Welcome