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

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 □ Declined

Ethnicity: □ Hispanic or Latino □ Non-Hispanic or Non-Latino □ Declined

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 □ Patient Portal □ Declined

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

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

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 _____

Mother's Maiden Name _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Date of Birth _____ SS # Email Address_____

Father's Full Name _____ Employer _____ Work Phone _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Date of Birth _____ SS # Email Address_____

Child Resides with: _____

Other children in the family treated in our office:

(1) Child's Full Name: _____ DOB: _____

(2) Child's Full Name: _____ DOB: _____

(3) Child's Full Name: _____ DOB: _____

(4) Child's Full Name: _____ DOB: _____

******Insurance Information***** Please provide card for receptionist to copy*

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 02/15