CORNERSTONE
family medicine

REGISTRATION

PATIENT INFORMATION

Last Name: ______________________________ **First Name:** __________________________ **Middle Name:** _______________

Social Security: _____-______-________ **Date of Birth:** _________/______/______ **Email:** ____________________________________
YYYY MM DD

Address: ____ **Apt:** _______ **City:** _______________ **State:** ______ **Zip:** ____________

Home phone: ____ **Cell Phone:** ____

How did you hear about our office? ☐Insurance ☐Family/Friend ☐Online ☐Mailer

Sexual Orientation: ☐Straight/Heterosexual ☐Homosexual ☐Bisexual ☐Lesbian/Gay ☐Prefer not to answer

Gender Identity: ☐Identifies as Male ☐Identifies as Female ☐Transgender (FTM) or (MTF) Gender Non-Conforming ☐Other ☐Prefer not to answer

Pronouns: ☐He/Him ☐She/Her ☐They/Them

Gender Assigned at Birth: ☐Male ☐Female ☐Unkown ☐Prefer not to answer

Marital Status: ☐Single ☐Married ☐Partner ☐Divorced ☐Separated ☐Widowed

Race: ☐Caucasian ☐African American ☐Asian ☐Hispanic/Latino ☐Middle Eastern ☐Native American ☐Pacific Islander ☐Prefer not to answer

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Other

Primary Language: ☐English ☐Spanish ☐Other

EMERGENCY CONTACT INFORMATION

Name: ______________________________ **Relationship:** _________________ **Phone Number:** ___________________________

Name: ______________________________ **Relationship:** _________________ **Phone Number:** ___________________________

INSURANCE INFORMATION

Primary Insurance Name: ____________________________________ **Insurance Phone:** _____________________________

Policy Holder Name: __________________________ ____________________________ __________ **DOB:** ______/______/_______
Last First MI

Social Security: _______-________-________ ☐Male ☐Female **Relationship to Patient:** ___________________________________

ID Number: ___________________________________ **Group Number:** ____

Secondary Insurance Name: __________________________________ **Insurance Phone:** _____________________________

Policy Holder Name: __________________________ ____________________________ __________ **DOB:** ______/______/_______
Last First MI

Social Security: _______-________-________ ☐Male ☐Female **Relationship to Patient:** ___________________________________

ID Number: ___________________________________ **Group Number:** ____

RELEASE OF BENEFITS AND ACKNOWLEDGEMENT

I attest that the information is correct to the best of my knowledge. I authorize the release of any medical information that may be requested by the above-named insurance carrier(s) in order to process a claim for benefits.

Patient Name: ___________________________ **Patient Signature:** ____________________________ **Date:** ________________

If Minor: Parent/Legal Guardian Name: ____________________ **Signature:** _____________________ **Date:** ________________

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FINANCIAL / PRIVACY

Name: **DOB:**

CONSENT FOR CARE AND TREATMENT

I understand and agree to give my consent to Cornerstone Family Medicine (CFM) to provide medical care, recommendations and treatment considered necessary and proper in diagnosing or treating the undersigned patient.

Patients Name: ________________________________ DOB: ______________

Patient/Responsible Party Signature: ________________________________ Date: ______________

FINANCIAL POLICY/NOTIFICATION OF PATIENT RESPONSIBILITY

CFM will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when services are rendered. It is the responsibility of the patient to make sure we are assigned as your PCP and in your network. It is s the responsibility of the patient to be sure they acquire the appropriate referrals and or prior authorizations as needed by the insurance. In the event your insurance company establishes a usually and customary fee schedule, you will be responsible for the remaining balance.

_____ If any payment is made directly to you for services billed, you will recognize an obligation to submit same payment to CFM.
Initial

_____ **Insurance companies require us to collect your co-payments, co-insurance, and/or any unmet deductible amount(s) from you at the time of services.**
Initial

_____ In the even that a personal check is returned for Non-Sufficient Funds, a $50 service fee will be charged to you.
Initial

CANCELLATION POLICY

_____ We Charge a $25 fee if you do not cancel within 24 hours or show to a scheduled office appointment.
Initial We charge a $50 fee if you do not cancel within 24 hours or show to a scheduled Ultrasound appointment.

ACKNOWLEDGEMENT

Cornerstone Family Medicine reserves the right to refuse service to anyone at our discretion in non-emergency situation. By signing below, I acknowledge that I have read the above information. I am ultimately financially responsible for my treatment and will be responsible for all costs of collecting monies owed, including but not limited to costs from a collection agency and/or attorney's fees.

Patient/Responsible Party Signature: ________________________________ Date: ______________

HIPAA / HIE

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I have been informed of CFM's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my healthcare information. I understand that I may request in writing that CFM restricts how my private information is used or disclosed to carry out treatment, payment, or health care operations. I understand that I may revoke this consent in writing at any time, except to the extent that CFM has acted relying on this consent.

Patients Name: ________________________________ DOB: ______________

Patient/Responsible Party Signature: ________________________________ Date: ______________

_____ I acknowledge that I have received a copy of the Privacy Practices for CFM which is also available on my patient portal.
Initial I understand and have read the Notice of Health Information Practices regarding my provider's participation in the statewide Health Information Exchange (HIE), or I have previously received this copy and decline another copy.

_____ CFM has authorization to leave a message on your home/cell answering machine regarding appointments, labs, imaging, billing, and insurance information.
Initial

AUTHORIZED PERSONNEL

The personnel below are authorized to receive/discuss information regarding my medical care such as appointments, lab/imaging results, messages from medical staff, billing and insurance.

Authorized Person: ____________________ Relationship: ______________ Phone Number: ______________

Authorized Person: ____________________ Relationship: ______________ Phone Number: ______________

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MEDICAL HISTORY 1 of 2

PHARMACY

Primary: ______________________ **Address:** ______________________

Mail Order: ______________________ **Address:** ______________________

ALLERGIES

Name	Reaction	Severity

CURRENT MEDICATIONS / VITAMINS / SUPPLEMENTS (Use back of form for more room)

Medication	Dose	Directions	Medication	Dose	Directions
1.			5.		
2.			6.		
3.			7.		
4.			8.		

SPECIALISTS

Office Name	Address

MEDICAL HISTORY

Year
- _____ ☐ ADHD
- _____ ☐ Allergies
- _____ ☐ Anxiety
- _____ ☐ Arthritis *site* _____
- _____ ☐ Asthma
- _____ ☐ Atrial Fibrillation
- _____ ☐ Benign Prostatic Hypertrophy
- _____ ☐ Blood Clots *site* _____
- _____ ☐ Cancer *type* _____

Year
- _____ ☐ CVA/Stroke/TIA
- _____ ☐ COPD
- _____ ☐ Coronary Artery Disease
- _____ ☐ Depression
- _____ ☐ Diabetes *type* _____
- _____ ☐ GERD (Acid Reflux)
- _____ ☐ Hyperlipidemia (Cholesterol)
- _____ ☐ Hypertension (High Blood Pressure)
- _____ ☐ Hypothyroidism (Thyroid)

Year
- _____ ☐ Irritable Bowel Disease
- _____ ☐ Migraines / Headaches
- _____ ☐ MI (Heart Attack)
- _____ ☐ Osteoporosis
- _____ ☐ Renal / Kidney Disease
- _____ ☐ Seizure Disorder
- _____ ☐ Sleep Apnea
- _____ ☐ Hypothyroidism (Thyroid)
- _____ ☐ Other ______________________

Year
- _____ ☐ Appendectomy
- _____ ☐ Arthroscopy Knee *side* _____
- _____ ☐ Back Surgery *site* _____
- _____ ☐ CABG (Heart Bypass)
- _____ ☐ Cataract Extraction *side* _____
- _____ ☐ Cholecystectomy (Gall Bladder)
- _____ ☐ Colectomy (Colon Removed)
- _____ ☐ Colostomy Bag
- _____ ☐ Gastric Bypass
- _____ ☐ Hernia Repair *site* _____

Year
- _____ ☐ Hip Replacement *side* _____
- _____ ☐ Knee Replacement *side* _____
- _____ ☐ Thyroidectomy *side* _____
- _____ ☐ Tonsillectomy

MALE
- _____ ☐ Prostate Biopsy
- _____ ☐ TURP
- _____ ☐ Vasectomy
- _____ ☐ Other ______________________

Year **FEMALE**
- _____ ☐ Bilateral Tubal Ligation
- _____ ☐ Breast Biopsy *side* _____
- _____ ☐ Cesarean Section
- _____ ☐ D & C
- _____ ☐ Hysterectomy *partial* _____
- _____ ☐ Mastectomy *side* _____
- _____ ☐ Reduction Mammoplasty
- _____ ☐ Other ______________________

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MEDICAL HISTORY 2 of 2

Name: **DOB:**

FAMILY HISTORY

Diagnosis	Immediate Family Member(s)	Age of Death	Cause of Death
ADHD			☐ Yes
Alcoholism			☐ Yes
Alzheimer's Disease			☐ Yes
Asthma			☐ Yes
CAD (Coronary Artery Disease)			☐ Yes
Cancer – *type*			☐ Yes
CVA (Stroke)			☐ Yes
Depression			☐ Yes
Diabetes			☐ Yes
Hyperlipidemia (Cholesterol)			☐ Yes
Hypertension (High Blood Pressure)			☐ Yes
Irritable Bowel Disease			☐ Yes
Osteoarthritis			☐ Yes
Osteoarthritis			☐ Yes
PVD (Vascular Disease)			☐ Yes
Renal / Kidney Disease			☐ Yes
Seizure Disorder			☐ Yes
Other:			☐ Yes

SOCIAL HISTORY

Tobacco Use

☐ Never

☐ Current **How many packs a day?** _____ **How many years?** _____ **Type:** ☐Cigarette ☐Vape ☐Chewing ☐ Cigar

☐ Former **How many packs a day?** _____ **How many years?** _____ **Year Quit:** _____ **Type:** ☐Cigarette ☐Vape ☐Chewing ☐ Cigar

Alcohol Use	**Caffeine Use**
☐ No	☐ No
☐ Social / Occasional	☐ Yes **Quantity: Day** _____
☐ Yes **Quantity: Day** _____ **Week** _____ ☐Beer ☐Wine ☐ Liquor	

HEALTH MAINTENANCE

Screening	Date	Immunizations	Date	Females	Date
☐ Annual Exam	______/______/_______	☐ Influenza Vaccine	______/______/_______	☐ DEXA (65+)	______/______/_______
☐ EKG	______/______/_______	☐ Pneumonia Vaccine	______/______/_______	☐ Mammogram (40+)	______/______/_______
☐ Cologuard	______/______/_______	☐ Shingles Vaccine	______/______/_______	☐ PAP (21-65)	______/______/_______
☐ Colonoscopy (45+)	______/______/_______	☐ Tetanus Vaccine	______/______/_______	**Males**	
☐ Diabetic Eye Exam	______/______/_______	☐ Tdap Vaccine	______/______/_______	☐ PSA (55+)	______/______/_______
☐ Diabetic Foot Exam	______/______/_______				

LIFESTYLE HISTORY *(For Insurance Purposes)*

Do you get up in the middle of the night to use the restroom? ☐ Yes ☐ No

Have you fallen in the last year? ☐ Yes ☐ No **Number of Falls?** _____ **Do you use a walker or cane?** ☐ Yes ☐ No

Do you use a seat belt? ☐ Yes ☐ No

Do you have Smoke Detectors in home? ☐ Yes ☐ No **Do you have Carbon Monoxide Detectors in home?** ☐ Yes ☐ No

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Phone: (480)981-6100 Fax: (480)981-5501

RECORDS REQUEST

PATIENT INFORMATION

Name: ______________________________, ______________________________ **DOB:** ____/____/______
Last *First* *MM* *DD* *YYYY*

FACILITY

☐ Release requested information from personnel below to Cornerstone Family Medicine:

Office Name: ______________________________

Address: ______________________________ __________ ______ __________
City *State* *Zip*

Phone: ______________________________ **Fax:** ______________________________

FACILITY

☐ Cornerstone Family Medicine will release requested information to personnel below:

Office Name: ______________________________

Address: ______________________________ __________ ______ __________
City *State* *Zip*

Phone: ______________________________ **Fax:** ______________________________

REQUESTED INFORMATION

☐ Last 2 years of Medical Records
☐ Last Office Notes
☐ Labs
☐ Radiology
☐ Other: ______________________________

RELEASE ACKNOWLEDGEMENT

I authorize release of my healthcare information to those requested above. I acknowledge that I may revoke this authorization by notifying Cornerstone Family Medicine in writing. I understand healthcare information that may have already been disclosed cannot be reversed. I understand that if this information is disclosed to a third party, the information may no longer be protected by state or federal regulations and may be re-disclosed by the person or organization that receives the information. This authorization is valid for 24 months.

Patient Signature: ______________________________ Date: ______________