

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

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 _____

Insurance Information

Effective Date _____ Copy of _____ ID # _____

Name of Insurance Company _____ Card Provided **OR** Group # _____

Name of Insured (Subscriber) _____ **Pt Relationship to Insured:** 1 Self 2 Spouse 3 Child

Insured Address _____ City/State/Zip _____

Date of Birth _____ SS # _____ Home Phone _____

Name of Employer _____ Work Phone _____ Ext. _____

Employer Address _____ City/State/Zip _____

*****DO YOU HAVE ADDITIONAL INSURANCE? YES NO **IF YES, COMPLETE THE FOLLOWING:** *****

Effective Date _____ Copy of _____ ID # _____

Name of Insurance Company _____ Card Provided **OR** Group # _____

Name of Insured (Subscriber) _____ **Pt Relationship to Insured:** 1 Self 2 Spouse 3 Child

Insured Address _____ City/State/Zip _____

Date of Birth _____ SS # _____ Home Phone _____

Name of Employer _____ Work Phone _____ Ext. _____

Employer Address _____ City/State/Zip _____

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.

Signature: _____ Date: _____

Patient/Parent/Person Financially Responsible