CORNERSTONE
family medicine

Registration

Patient Information

☐ Demographic Update

Last name _____ First Name _____ Middle Name _____

Social Security ___-___-___ Birth Date ___/___/___ ☐ Female ☐ Male Gender

Address _____ Apt # _____ City _____ State _____ Zip _____

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

Race ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic/Latino ☐ Middle Eastern ☐ Native American ☐ Pacific Islander ☐ Other ☐ Do Not Wish to Disclose

Home Phone ☐ Primary (___) ___-___ Day Phone ☐ Primary (___) ___-___ Alternative Phone ☐ Primary (___) ___-___

Emergency Contact Full Name _____ Emergency Contact Phone (___) ___-___

Email Address _____ How Did You Hear About Our Office? _____

Guarantor Information

☐ Guarantor Same As Above

Guarantor Last name _____ Guarantor First Name _____ Middle Name _____

Social Security ___-___-___ Birth Date ___/___/___ ☐ Female ☐ Male Gender

Address _____ Apt # _____ City _____ State _____ Zip _____

Guarantor Relationship _____ Home Phone (___) ___-___ ☐ Primary Day Phone (___) ___-___ ☐ Primary

Insurance Information

☐ Policy Holder Same As Above

Policy Holder Last name _____ Policy Holder First Name _____ Middle Name _____

Social Security ___-___-___ Birth Date ___/___/___ ☐ Female ☐ Male Gender

Address _____ Apt # _____ City _____ State _____ Zip _____

Policy Holder Relationship _____ Home Phone (___) ___-___ ☐ Primary Day Phone (___) ___-___ ☐ Primary

Primary Insurance Company _____ Policy Number _____ Group Number _____

Secondary Insurance Company _____ Policy Number _____ Group Number _____

Acknowledgment

I certify that the above information is true and correct. I hereby authorize release of any and all medical information that may be requested by the above named insurance carrier(s) in order to process a claim for benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I am financially responsible for all charges accumulated from any missed appointments that were not cancelled by the patient at least 24 hours prior to my scheduled appointment. In the event of default and the account is placed with a collection agency, I agree to pay the fees of the collection agency equal to a maximum of 50% of the outstanding balance at the time the account is placed with the agency and interest accrual of 10% per year on the principal balance. Should legal action be necessary to collect the account, I agree to pay attorney fees and court costs that occur.

Patient Signature (If Minor: Parent / Legal Guardian) _____ Date ___/___/___

Patient Name _____DOB _____

CORNERSTONE FAMILY MEDICINE

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 by you of your *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 you restrict 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 you have taken action relying on this consent.

I understand that we are required to have authorization to leave a message at your home or on your answering machine, regarding appointments, labs, imaging, and billing and insurance information

Patient Signature _____Date _____

I acknowledge that I have received a copy of the Privacy Practices for Cornerstone Family Medicine. I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

Authorized Person _____ Relationship to Patient _____

Authorized Person _____ Relationship to Patient _____

Authorized Person _____Relationship to Patient _____

Authorized Person _____ Relationship to Patient _____

Acknowledgment of Receipt of Privacy Practices

I acknowledge that I have receive a copy of the Privacy Practices for Cornerstone Family Medicine

_____ _____

Patient Parent of legally authorized individual

_____ _____

Date Relationship to Patient

Cornerstone Family Medicine

Medical History

PLEASE COMPLETE EACH SECTION IN ITS ENTIRETY

Name _____ **DOB** _____

Pharmacy

Primary _____ **Cross Streets** _____

Secondary or Mail Order _____ **Cross Streets** _____

Advanced Directives

Type □ None □ Refuse □ Do Not Resuscitate **Effective**

□ Living Will □ Do Not Place On Life Support □ Power of Attorney **Date** ____/____/_____

Allergies □ No Allergies

Please Specify Allergy & Reaction

_____ _____

_____ _____

_____ _____

Medications / Vitamins / Supplements □ No Medications

If you have more than 8 medications please attach list or write on back of page

Medication Name	Strength	Directions
_____	_____	_____
_____	_____	_____
_____	_____	_____

Specialist Doctors

_____

_____

Medical/Surgical History □ No Relevant History

Medical History

Year		Year		Year	
_____	□ Allergies	_____	□ COPD	_____	□ Liver Disease
_____	□ Anemia	_____	□ Coronary Artery Disease	_____	□ Migraine / Headaches
_____	□ Angina (chest pain)	_____	□ Crohn's Disease	_____	□ MI (heart attack)
_____	□ Anxiety	_____	□ Depression	_____	□ Osteoporosis
_____	□ Arthritis *Site*_____	_____	□ Diabetes I or II	_____	□ Peptic Ulcer Disease
_____	□ Asthma	_____	□ Gallbladder Disease	_____	□ Renal/Kidney Disease
_____	□ Atrial Fibrillation	_____	□ GERD (acid reflux)	_____	□ Seizure Disorder
_____	□ Benign Prostatic Hypertrophy	_____	□ Hepatitis A, B or C	_____	□ Thyroid Disease
_____	□ Blood Clots *Site*_____	_____	□ Hyperlipidemia (Cholesterol)	_____	□ Other _____
_____	□ Cancer *Type* _____	_____	□ HTN (High blood pressure)	_____	□ Other _____
_____	□ CVA/Stroke/TIA	_____	□ Irritable Bowel Disease	_____	□ Other _____

Past Surgical History

Year		Year		Year	Females Only
_____	□ Appendectomy	_____	□ Gastric Bypass	_____	□ Bilat. Tubal Ligation
_____	□ Arthroscopy Knee *Side* ___	_____	□ Hernia Repair *Site* _____	_____	□ Breast Biopsy *Side* _____
_____	□ Back Surgery *Site* ___	_____	□ Hip Replacement *Side* ___	_____	□ Cesarean Section
_____	□ CABG (Heart Bypass)	_____	□ Knee Replacement *Side* ___	_____	□ D and C
_____	□ Cataract Extraction *Side* __	_____	□ Pacemaker / Defibrillator	_____	□ Hysterectomy *Partial* ___
_____	□ Cholecystectomy(gall bladder)	_____	□ Small Bowel Resection	_____	□ Mastectomy *Side* ___
_____	□ Colectomy(colon removed)	_____	□ Thyroidectomy *Side* ___	_____	□ Reduction Mammoplasty
_____	□ Colostomy bag	_____	□ Tonsillectomy	_____	**Males Only**
				_____	□ Prostate Biopsy
				_____	□ TURP
				_____	□ Vasectomy

Additional History

_____

_____

□ Patient Adopted **Family History** **□ No Relevant History**

Diagnosis	Family Member(s) Immediate Family/Blood Relatives	Age of Death	Cause of Death
ADD/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
HTN (High Blood Pressure)			□ Yes
Irritable Bowel Disease			□ Yes
Mental Illness			□ Yes
Osteoarthritis			□ Yes
Osteoporosis			□ Yes
PVD (Vascular Disease)			□ Yes
Renal/Kidney Disease			□ Yes
Seizure Disorder			□ Yes
Other_____			□ Yes

Social History

Race □ African American/Black □ Caucasian/White □ Pacific Islander/Native Hawaiian
□ American Indian/Alaska Native □ Hispanic/Latino □ Other
□ Asian □ Middle Eastern □ Do Not Wish To Disclose

Ethnicity □ Hispanic/Latino Origin □ No Hispanic/Latino Origin □ Unknown

Primary Language Spoken □ English □ Spanish □ Other _____

Language Spoken At Home □ English □ Spanish □ Other _____

Country Of Birth □ USA □ Other _____

Employer (Name) _____ **Occupation (Type Of Work)** _____

Employment Status □ Full Time □ Self-Employed □ Retired *Date* ___/___/___
□ Part Time □ Unemployed □ Other _____

Marital Status □ Married □ Life Partner □ Widowed
□ Single □ Legally Separated □ Other _____
□ Divorced □ Annulled

Has Children □ No □ Yes **Number of Sons** _____ **Number of Daughters** _____

Tobacco/Alcohol/Caffeine

Uses Tobacco □ Current □ Former □ Never

Tobacco Type □ Cigarette □ E-Cigarette **Units/Day** _____
□ Chewing □ Pipe **Years Used** _____
□ Cigar □ Smokeless

Ever Tried To Quit? □ No □ Yes **Year Quit** _____ **Second Hand Smoke Exposure** □ No □ Yes

Smoker Status □ Current Every Day Smoker □ Smoker, Status Unknown □ Former Smoker
□ Current Some Day Smoker □ Never Smoker □ Unknown If Ever Smoked

Drinks Alcohol □ No □ Yes* □ Formerly* **Caffeine** □ No □ Yes
*If yes or formerly how many drinks? ____/day ____/week

Urinary concerns Do you get up in the middle of the night to go to the bathroom? □ No □ Yes

Lifestyle – Other

Hand Dominance □ Right □ Left □ Ambidextrous

Activity Level □ Moderate □ Sedentary □ Vigorous **Type of Exercise** _____

Exercise Frequency (Hours per day/days per Week) _____

Hobbies/Activities _____

Current Diet

□ Diabetic □ Vegan □ Vegetarian □ High Fiber □ Low Sodium □ High Protein □ Other

Animals In The Home

□ No □ Yes *Type* _____

Lifestyle – Home Environment/Safety *(For Insurance Company Purposes)*

Smoke Detectors In Home □ No □ Yes **Carbon Monoxide Detectors In Home** □ No □ Yes

Seat Belt Use □ No □ Yes **Falls In The Last Year** □ No □ Yes Number/Falls _____ □ Walker □ Cane

Disease Management

Health Maintenance

	Date		Date	Females Only	Date
□ H&P (Physical Exam)	___/___/___	□ Influenza Vaccine	___/___/___	□ GYN Exam	___/___/___
□ Lipid Panel	___/___/___	□ Pneumonia Vaccine	___/___/___	□ Breast Exam	___/___/___
□ EKG	___/___/___	□ Shingles Vaccine	___/___/___	□ Pap	___/___/___
□ Colonoscopy	___/___/___	□ Tdap Vaccine	___/___/___	□ Mammogram	___/___/___
□ Stool Card	___/___/___	□ Eye Exam Glaucoma	___/___/___	□ Dexa Scan	___/___/___
□ Diabetic Foot Exam	___/___/___	□ Diabetic Eye Exam	___/___/___	**Males Only**	**Date**
				□ PSA	___/___/___

Patient Name_____**DOB**_____**Date**_____

Over the last 2 weeks, how often have you been bothered by any of the following problems (circle your number)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
If you checked off any problems how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not very difficult ☐		Somewhat difficult ☐	
	Very difficult ☐		Extremely difficult ☐	

How often do you have a drink containing alcohol?

- ☐ *A. Never*
- ☐ *B. Monthly or less*
- ☐ *C. 2-4 times a month*
- ☐ *D. 2-3 times a week*
- ☐ *E. 4 or more times a week*

How many standard drinks containing alcohol do you have on a typical day?

- ☐ A. 1 or 2
- ☐ B. 3 or 4
- ☐ C. 5 or 6
- ☐ D. 7 to 9
- ☐ E. 10 or more

How often do you have six or more drinks on one occasion?

- ☐ A. Never
- ☐ B. Less than monthly
- ☐ C. Monthly
- ☐ D. Weekly
- ☐ E. Daily or almost daily

Cornerstone Family Medicine

4545 E Southern Ave. Ste 103
Mesa, AZ 85206
Phone: 480-981-6100
eFax: 480-981-5501

I, _____, hereby authorize release of my healthcare information as described below.

1. The following person (s) or facility named below are authorized to disclose my healthcare information as requested to Cornerstone Family Medicine.
2. The following person(s) or facility named above are authorized to release my healthcare information as requested.

Previous Physician's Name: _____

Address: _____

_____

Phone: _____ Fax: _____

The specific information to be disclosed includes:

_____ Healthcare information relating to the following condition or dates of treatment:

_____

_____ Last 2 years

_____ All healthcare information

****If more than 50 pages please mail****

I may revoke this authorization by notifying Cornerstone Family Medicine in writing of my intentions. I understand that my healthcare information may have already been disclosed and cannot be reversed.

I understand that my healthcare information that is disclosed may be subject to re-disclosure by the person(s) receiving it and may not be protected by federal privacy regulation.

This authorization expires on _____ or when the following event occurs: _____

_____

This form must be completed in its entirety before signing.

_____	_____	_____
Signature of Individual	Date signed	Date of Birth, or SocSec number
_____	_____	_____
Signature of Parent/Guardian/Representative	Date signed	Relationship to Individual