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** _____

Email Address _____

Home Phone (___) ___-___ ☐ Primary **Day Phone** (___) ___-___ Primary ☐ **Cell Phone** (___) ___-___ Primary ☐

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

How Did You Hear About Our Office? _____

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

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

Primary Language Spoken □ English □ Spanish □ Other _____

Language Spoken at home □ English □ Spanish □ Other _____

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** ___/___/___

Cornerstone Family Medicine

Financial Policy

Patient Name:_____ DOB: _____

Consent for Care and Treatment:

I, the undersigned, do hereby agree and give my consent to Cornerstone Family Medicine to provide medical care, recommendations and treatment considered necessary and proper in diagnosing or treating the above named patient.

Patient/Responsible Party Signature: Sign: _____Date:_____

Financial Policy/Notification of Patient Responsibility:

*Cornerstone Family Medicine 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 on your insurance and in your network. *It is 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 recognize an obligation to submit same payment to Cornerstone Family Medicine.

*Insurance companies require us to collect your co-payments, co-insurance, and/or any unmet deductible amounts from you at the time of services.

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

Insurance Verification:

We will/have verified your medical benefits with your insurance, based upon the information you provided. Please be aware that your insurance has a disclaimer that this is VERIFICATION OF BENEFITS only and does not guarantee payment. Benefits/payment is determined once the claim is received.

Cancellation Policy:

We do charge a $25 fee if you do not show up to a scheduled appointment or cancel the same day as your appointment. Please call us 24 hours in advance if you have to cancel your scheduled appointment. If you are scheduled for any ultrasound, and cancel the day of the appointment or no show, you will be charged a $50 fee. Please call us 24 hours BEFORE your appointment to reschedule. Initial:

We reserve the right to refuse service to anyone at our discretion in non-emergency situations.

By signing below, I acknowledge that I have read the above information, and that I am ultimately

financially responsible for my treatment. I understand and agree that if I fail to make any payment

that I am responsible for in a timely manner, I will be responsible for all costs of

collecting monies owed, including but not limited to costs, collection agency

and/or attorney's fees.

Patient/Guardian signature:_____ 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 _____

□ 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

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 – 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	___/___/___

Cornerstone Family Medicine

4545 E Southern Ave. Ste 103
Mesa, AZ 85206
Phone: 480-981-6100
Fax: 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 **(WE DON'T ACCEPT DISC)**

****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