Patient Information

Date:_____

Name: _____
First Middle Last Maiden

I prefer to be called: _____ Date of birth: _____

Address: _____
Street City State Zip

Home Phone #: _____ Work **#:** _____ Other #: _____

Email address: _____

Male ____ Female____ Marital Status: _____ **Social Security #**: _____
Ethnicity: ____not Hispanic or _____Hispanic Language: _____
Race: _____White; _____African American; _____ American Indian or Alaska Native;
_____ Asian; _____ Native Hawaiian or _____Other

Employer Name & Address: _____
Job Title or Description: _____
Where and when are the best times to reach you from 8am – 5pm? _____
Person responsible for account: _____

Insurance Carrier:

Name: _____ SSN # _____
First Middle Last

Address: _____Date of Birth_____
Street City State Zip

Home phone #: _____ Relationship to patient: _____

Employer Name & Address: _____

Work #: _____ Other #: _____

Authorization for Medical Information

I authorize information about my visits and account to be released to:

Mother-Name _____
Father-Name _____
Spouse/Partner _____
Other-Name _____

I authorize that my lab results may be left:

On my answering machine/voice mail _____
On my voice mail at work _____
On my cell phone's voice mail # _____
Other _____

Pharmacy number: _____
Email: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Home phone #: _____ Work #: _____

Other #: _____

The patient (parent/guardian) is responsible for all fees, regardless of insurance coverage. This includes, but is not limited to, co-insurance, co-payment, deductible, and non-covered services.

I hereby authorize Cornerstone Family Physicians, P.C. to furnish insurance companies or their representative's information concerning my (my dependent's) illness and treatments. I hereby assign to Cornerstone Family Physicians, P.C. all payments for medical services rendered to myself (or dependent). I understand I am responsible for any amount not covered by insurance. I agree that should this account become delinquent I am responsible for any attorney fees and other costs of collection.

_____ Date: _____
Signature of Patient

_____ Date: _____
Signature of Parent or Guardian

Please bring your insurance card to the front desk for us to photocopy.