Cornerstone OBGYN

Patient Registration Information

Social Security #: _____ Driver's License #: _____ State: _____

Name: _____ _____ _____ _____ _____ S M D W
Last First M.I. Sex Date of Birth Age Marital Status

Address: _____ _____ _____ _____ _____
Street or P.O. Box Apt City ST Zip

Email Address: _____

Please indicate preferred contact number, including location

Cell #1_____ Home #2_____ Work #3_____

Employer or School Name: _____

Employer's Address: _____ _____ _____ _____
Street or P.O. Box City ST Zip

Occupation: _____

Emergency Contact:_____ _____ _____ _____
Name DOB Phone Relationship

Responsible Party and Billing Information

Patient is responsible party, however if the patient is a minor the guardian's information should be listed in this section.
Patient Relationship to Responsible Party: Child: _____ Other (Specify): _____

Social Security #: _____ Driver's License #: _____ State: _____

Name: _____ _____ _____ _____ _____ S M D W
Last First M.I. Sex Date of Birth Age Marital Status

Address: _____ _____ _____ _____ _____
Street (no P.O. Box's please) Apt City ST Zip Home Phone

Full-Time Part-Time Retired Unemployed Student Occupation: _____
Employment Status (please circle one)

Employer or School Name: _____ _____ _____
Work Phone Ext

Employer's Address: _____ _____ _____ _____
Street or P.O. Box City ST Zip

Spouse Information

Spouse Name: _____ DOB: _____ SS#:_____

Spouse's Wk Phone: _____ Occupation: _____

Primary Insurance (Please provide copy of card to receptionist)

Insurance Company: _____ Address: _____
Street or P.O. Box

Ins. Phone _____ _____ _____ _____
City ST Zip

Policy Holder: _____ _____ _____ _____
Last First Sex Date of Birth SS#

Patient Relationship to Insured Party: Self _____ Spouse _____ Child _____ Other (Specify)_____

Employer's Name: _____ _____ _____
Insured ID Group Number

Address: _____ _____ _____ _____
Street or P.O. Box City ST Zip

Preferred Pharmacy (include location and phone number):_____ _____ _____
Name Location Phone #

REFERRAL INFORMATION

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES/ APPOINTMENT OF AUTHORIZED REPRESENTATIVE

PLEASE READ:

I authorize qualified staff to perform upon me, rehabilitation, therapy and/or any other care including treatment necessary to improve my well being. I acknowledge that no guarantees can be made to me as to the outcome of treatment. I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

PATIENT SIGNATURE: _____ DATE: _____

I authorize my insurance benefits to be paid directly to my physician realizing I am responsible to pay non-covered and/or denied services. In the event that my insurance carrier denies payment for any reason, I acknowledge that I am responsible for payment of services provided to me.

PATIENT SIGNATURE: _____ DATE: _____

I authorize the release of information to my insurance carrier named above concerning my medical condition and for the purpose of claims processing. I also authorize the release of medical information to my referring physician and any physician I am recommended to see for continuation of care. I understand that the release of information will only consist of medical records belonging to Dr. Choudhry, Dr. Anger, Dr. Duncan or Dr. Bookout of Cornerstone OBGyn.

PATIENT SIGNATURE: _____ DATE: _____

I understand that this is an appropriate request that I can make in our patient physician relationship and follows the guidelines of medical confidentiality.

PATIENT SIGNATURE _____ DATE:_____