CORNERSTONE
FAMILY MEDICINE

9310 Old Kings Rd, Suite 3103
Jacksonville, FL 32257
Tel. No. : 904.900.3472
Fax No. :904.503.2373

Patient Medical History Questionnaire

Patient Name: _____ Date of Birth: _____ Sex: _____
Who referred you for this visit? _____ ☐ Not Applicable
Reason for seeing the Doctor :_____
Are you here because of injury? ☐ Yes (Date of Injury ___/___/_____, Circle one WORK or AUTO) ☐ No

Past Medical History

Do you have, or had, any of the following: (PLEASE CIRCLE)

Diabetes	High blood pressure	Heart Condition	Seizure	Sleep apnea
Ulcer	Cancer	Phlebitis or blood clots	Stroke	Asthma
Emphysema	Complication of anesthesia	Kidney stones		

List other medical conditions and/or illness not mentioned above _____
_____
List reasons for hospitalizations and/or surgeries with dates and any complications _____
_____
List any significant injuries you have sustained _____

Family History (if deceased, please provide age and cause)
Age(s) and overall health of parents _____
Age(s) and overall health of sibling(s) _____
List of any significant family health problems _____

Social History
Marital status _____ Education (Years /Degrees) _____
Alcohol use (Type/amount) _____ Tobacco use (Amount/years used) _____
Employer _____ Occupation _____
LIST ANY DRUG ALLERGIES: _____ Latex Allergy? ☐ Yes ☐ No
LIST CURRENT MEDICATIONS: _____
_____
Review of Systems (Circle positive symptoms and describe and/or add others, if needed.

Constitutional: Fever, weight gain/loss, loss of appetite

Eyes: Double vision, blurring, difficulty seeing

ENT: Deafness, sinusitis, hoarseness, vertigo

Cardiovascular: Chest pain, murmur, palpitations, irregular/rapid heartbeat

Respiratory: Shortness of breath, wheezing, spitting blood, chronic couch

Digestive: Abdominal pain, constipation, diarrhea, bleeding

Urologic: Pain when urinating, hesitancy, bleeding, incontinence

Skin: Rashes, lesions that do not heal, changes in moles.

Gynecologic: Breast masses, pain, discharge problems

Neurologic: Seizures, loss of balance/coordination, paralysis, weakness, loss of memory

Psychiatric: Depression, anxiety, hallucinations, sleep disturbances.

Endocrine: Excessive thirst, excessive urination, heat/cold intolerance

Blood and Lymph: Anemia, bleeding tendencies, swollen nodes

Musculoskeletal: Stiffness, joint pain/deformity, muscle wasting, spine pain, radiating to arm/leg

Other: _____

_____ _____
Patient Signature **Date**

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Patient Registration

Patient Information

Name: _____ Date of Birth _____ / _____ / _____

Social Security #:_____ Preferred Language: _____ Race:_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Minor

Address: _____ City/State: _____ Zip: _____

Home Phone: _____Cell: _____ Email: _____

Advance Directive? _____ *Please attach or bring to your next appointment

Employer: _____ Occupation: _____ Work Phone: _____

Spouse (Guardian, if Minor) _____ Phone: _____

Emergency Contact: _____ Phone: _____

Emergency Contact Address :_____

Responsible Party

☐ Self or Name _____ Relationship to Patient _____

Date of Birth _____/ _____/ _____ Social Security# : _____ Home Phone: _____

Driver License _____

Insurance Information

Please let us make a copy of your insurance card and driver's license.

Primary Insurance Policy Holder Name _____

Relationship to Patient _____ Date of Birth _____/ _____/ _____ Social Security # _____

Insurance Carrier _____ Policy# _____ Group #_____

Secondary Insurance Policy Holder Name _____

Relationship to Patient _____ Date of Birth _____/ _____/ _____ Social Security # _____

Insurance Carrier _____ Policy# _____ Group #_____

3) Medicare #_____

I Authorize the release of any medical information necessary to process this claim.
I authorize payment of insurance benefits to Cornerstone Family Medicine for services rendered.
I certify that the information I have reported with regard to my insurance coverage is correct.
I understand that I am financially responsible for all charges not covered by my insurance company.

Signature: _____ Date : _____

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HEALTH CARE STATUS AUTHORIZATION

Declaration

I, _____ (name of patient) hereby give authorization to Cornerstone Family Medicine for the release of information concerning the status of my health care, including results of laboratory and radiology tests and to discuss my plan of treatment with:

_____
Name of Authorized Individual

_____
Relationship to Patient

I understand that I may revoke this authorization at any time

_____
Patient Signature

_____
Witness

_____
Date

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HIPAA Acknowledgement

Notice of Privacy Practices

Patient's Rights and Responsibilities (posted in lobby)

I have received the forms mentioned above and I have been provided an opportunity to review it.

Patient's Name: _____ Date of Birth: _____ / _____ / _____

Signature: _____ Date: _____

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OFFICE POLICIES

1) Please allow 24 hours to notify us prior to your appointment for cancellation and rescheduling. Failure to comply will result in a $25 charge and is due and payable by your next appointment.
2) Three scheduled appointments that are missed without proper notification are grounds for dismissal from the practice.
3) The patient is responsible to provide us with the current names of all insurance companies with whom they have policies, and to notify us of any changes that may occur for all subsequent visits. This includes group, individual policies, etc.
4) Co-payments are due at time of service, unless prior arrangements have been made in writing.
5) Please be aware that the patient is responsible for maintaining referrals as needed by their insurance carrier.
6) Cornerstone Family Medicine will file with your insurance company on your behalf, however, after a reasonable amount of time, charges not paid/ or remaining balance not covered by the insurance company will be billed to you for payment. Please cooperate with your insurance company in furnishing any forms or information the require from you. Should you be ruled ineligible, our fees will be billed to you at our regular scheduled charges.
7) The assignment of insurance benefits does not alter the patient's obligation to pay. All charges resulting from services rendered are due when statements are presented.
8) There is a $25 charge for disability or insurance forms filled out by Cornerstone Family Medicine's staff, on a per form basis.
9) Please keep your appointment in a timely manner.
10) Wiretapping of any communications by a third party is strictly prohibited.
11) No Narcotics will be given repeatedly without medical records from Pain Management provider.
12) Patients with chronic pain will be referred to Pain Management for better control.
13) The patient will use prescription or medical devices for oneself only.
14) The patient will inform the practitioner if one's condition worsens, or unexpected reaction occurs from medications.
15) Maintain a respectful behavior towards staff and other patients.

Our staff will be glad to discuss any questions you have concerning any of the policies stated. Please let us know how we may assist you.

I hereby authorize payment for my medical services to be made directly to Cornerstone Family Medicine, at their election, of any benefits due to me for services rendered.

I have read and fully understand the above office policies of Cornerstone Family Medicine.

_____	_____	_____
Print Patient Name	Signature	Date

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Notice

I agree that a No-Show Fee of $25.00 will be charged for any missed appointments without a 24 hours cancellation notice.

Patient Name: _____ Date: _____

Patient Signature: _____