CORNERSTONE
FAMILY MEDICINE

9310 Old Kings Rd, Suite 1303
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 #_____

Medicare # (if applicable) _____ Medicaid # (if applicable) _____

I authorize the release of any medical or other information necessary to process any claims for the physical and clinic.
I authorize payment of insurance benefits to Cornerstone Family Medicine for medical services rendered.
I certify that all the information I have provided in this application regarding my insurance coverage is true and 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 with Patient

I understand that I may revoke this authorization at any time

_____
Patient Signature

_____
Witness

_____
Date

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 with an opportunity to review it.

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

Signature: _____ Date: _____

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OFFICE POLICIES

1) Please keep your appointment in a timely manner. Your scheduled appointment time is reserved for you. If it is missed or cancelled or re-scheduled with less than 24-hour notice, you will be charged a **$25 No Show Fee/Last Minute Cancellation**. This is not covered by your insurance and is due and payable on your next appointment.

2) Three (3) repeated missed appointments without proper notification are grounds for dismissal from the practice.

_____ Initial

3) Patient is responsible to provide current and active insurance policies, and to notify us of any changes that may occur for all subsequent visits. This includes payer ID, group no., plan type, individual policies, claims address etc.

4) The assignment of insurance benefits does not alter the patient's obligation to pay. All charges from office visits, including phone consultations if necessary, and all services rendered, shall be billed to your insurance. If after a reasonable amount of time, charges are not paid and/or any remaining balance not covered by your insurance, it shall be your patient responsibility and will be billed to you for payment. Should you be ruled ineligible, you will be billed based on self-pay rates.

5) Co-payments/Co-insurance/Deductibles are your obligation set by your insurance plan and due at the time of service, or when statements are presented unless prior arrangements have been made in writing.

_____ Initial

6) Referrals and Drug Authorizations take about 5-14 days to process. Patient is responsible for maintaining referrals and any preventive screenings as recommended by the practitioner.

7) No Narcotics will be given repeatedly without medical records from Pain Management provider. Patients with chronic pain will be referred to Pain Management for better control.

8) Any medication refill must be requested at least 5-7 business days in advance before it is due. Since delays are unavoidable, it is the patient's responsibility to schedule office visit for medication refill appointments appropriately and to keep track of the amount of medication remaining, not to call for refills when medication is out.

9) Medication refills will only be made during regular business hours, not on Sundays, Mondays and holidays.

10) Patient will use prescription or medical devices for oneself only as prescribed. Patient to inform the practitioner if one's condition worsens, or unexpected reaction(s) occurs from medications.

11) It is a federal offense to alter script issued by the practitioner. Any violation will be reported to the proper authorities.

_____ Initial

12) There is a **$25 charge for any paperwork** from employment, school, insurance forms and disability filled out by the practitioner, on a per form/page basis or shall depend on extent of work. Patients must be treated in this clinic for his/her medical condition for at least three (3) months for any FMLA and six (6) months for Disability application.

_____ Initial

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13) Patient requesting for medical records, please allow 7-14 days to process. A fee of $1.00 per page applies for hardcopy.

14) Wiretapping, photo, audio or video recording of any communications inside or within the practice premises is strictly prohibited.

15) No pets are allowed unless it is a certified patient's service dog. Must show certificate.

16) Practitioners are not available after hours to handle emergencies. For life-threatening emergencies, patients are advised to dial 911 or go to the nearest emergency room/urgent care.

17) Patient and/or its representative should maintain respectful behavior towards staff, practitioners and other patients.

18) The practice has the right to refuse health service to anybody.

Our staff will be glad to discuss any questions you have concerning any of the policies stated.

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 will be financially responsible for the total charges of the services rendered for any claims not covered or denied by my insurance.

I agree to communicate and share information with Cornerstone Family Medicine via email and text messaging including images, documents etc., ensuring confidentiality and privacy. ☐ **YES** ☐ **NO**

I have read, fully understand and accept the above office policies of Cornerstone Family Medicine which serve as my patient contract, failure to adhere to this agreement could result in the dismissal of my care with the practice.

_____	_____	_____
Print Patient Name	Signature	Date

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Request for Medical Records

Records to be sent to the following address:

NAME: CORNERSTONE FAMILY MEDICINE LLC

ADDRESS: 9310 OLD KINGS RD. SOUTH SUITE 1303, JACKSONVILLE FL 32257

FAX: 904.503.2373

Records to be obtained from the following Physician/Facility:

Physician/Facility: _____

Address: _____

Telephone: _____ Fax: _____

Reason for release of records: _____

Dates of Service requested are: _____

I understand that the records being disclosed contain PHI. Consent [is given to disclose the following (check all that apply):

- ☐ All Medical Records
- ☐ Treatment Plan(s)
- ☐ HIV Test Results
- ☐ Bio Psychosocial Assessment
- ☐ Sexually Transmitted Diseases
- ☐ Hospital Notes
- ☐ Diagnostic Results (X-Ray/CT/MRI)
- ☐ Psychiatric evaluation(s)
- ☐ Accounting of Disclosures
- ☐ Physician's Progress Notes
- ☐ Medication Record/Prescriptions
- ☐ Laboratory Results
- ☐ Other: _____

As part of the medical record, the following information will be released unless prohibited:

SEXUAL ABUSE INFORMATION
DRUG AND ALCOHOL INFORMATION
CHILD ABUSE AND NEGLECTED INFORMATION
PSYCHIATRIC INFORMATION
AIDS/HIV

I have carefully read this consent, understand its contents and authorize the release of the above-specified information. This information is for the person/facility to which it is addressed only. This information is protected by the federal law. The information is used or disclosed pursuant to this authorization, maybe subject to disclosure by the recipient and no longer protected by federal law. I may cancel this authorization in writing at any time. This authorization will expire in one year from the date of signature.

Signature _____ Date _____

Patient Name _____ Date of Birth _____ / _____ / _____

If a patient is unable to sign due to mental or physical disability or is a minor, authorization must be signed by the legal guardian.