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: _____Relationship: _____ 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 physician 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 to 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 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. Scheduled appointment time is reserved especially for you. If an appointment is missed or cancelled with less than 24-hour notice, you will be charged a $25 No-Show Fee. This is not covered by your insurance and is due and payable at your next appointment.

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

3) Patient is responsible to provide current and active insurance policies, and to notify any changes that may occur for all subsequent visits. This includes 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 resulting from services rendered are due when statements are presented. If there are any forms or information your insurance requires from you, please cooperate with them. Should you be ruled ineligible, you will be billed based on self-pay rates.

5) Cornerstone Family Medicine will bill your insurance for all office visits including phone consults if necessary, however, you are responsible for co-payment amounts and deductibles set by your insurance plan. If after a reasonable amount of time, charges not paid and/or any remaining balance not covered by your insurance, shall be your patient responsibility and will be billed to you for payment.

6) Co-payment/Co-insurance are set by your insurance plan and due at time of service, unless prior arrangements have been made in writing.

7) Patient is responsible for maintaining referrals as recommended by the practitioner and any preventive screenings as required by the insurance carrier.

8) 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.

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

10) There is a $25 charge for any paperwork, employment/school, disability or insurance forms filled out by Cornerstone Family Medicine, on a per page basis.

11) Wiretapping, photo, audio or video recording of any communications by a third party inside or within the practice premises is strictly prohibited.

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

13) Maintain a respectful behavior towards staff, practitioners and other patients.

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 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 and fully understand the above office policies of Cornerstone Family Medicine which serves as my patient contract.

_____	_____	_____
Print Patient Name	Signature	Date