CORNERSTONE HEALTH AND FAMILY PRACTICE
2828 N. STONE
TUCSON, AZ 85705
520-622-4580 PH
520-622-4588 FAX

Welcome to Cornerstone Health and Family Practice. This letter is being presented at your initial encounter to clarify that we are not accepting chronic pain patients. Consequently if you are being treated for a condition requiring paid medication, your pain management will need to be provided by a provider outside of our clinic. At no point will we take over your pain management. Please acknowledge this agreement by signing below.

Signature_____

Date:_____

CORNERSTONE HEALTH AND FAMILY PRACTICE
PATIENT INFORMATION

Male_____ Female_____

Last Name:_____First Name:_____Middle initial_____

Social Security #_____Date of Birth:_____/_____/_____Marital Status_____

Address:_____City:_____State_____Zip_____

Home Phone#:_____Cell#:_____Message #:_____

Employer::_____Work phone :_____

Emergency
Contact:_____Relationship:_____Phone:_____

Address:_____City:_____State:_____Zip:_____

You must provide ALL insurances. Incomplete information will result in you being billed.

Primary Insurance:
Insurance Name_____
ID#_____ Group#_____
Name of Policy Holder_____
Relationship: _____
Social Security #_____
DOB _____ Phone #_____
Address:_____

Secondary Insurance:
Insurance Name _____
ID#_____ Group#_____
Name of Policy Holder _____
Relationship: _____
Social Security #_____
DOB_____ Phone #_____
Address_____

CONDITIONS OF FINANCIAL AGREEMENT

The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient he/she hereby individually obligates himself to pay the account of Dr. Shawn G. Platt, D.O in accordance with the regular rates and terms. Should the account be referred to a collection agency, the undersigned shall pay reasonable collections

SIGNATURE_____DATE:_____

(Parent or Legal Guardian)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGMENT OF BENEFITS

Thereby authorize Dr. Shawn G. Platt, D.O to release medical information to my insurance company concerning treatment of the above name patient while under care, and further authorized payment of any insurance benefits for medical or surgical services to Shawn G. Platt, D.O.

I HAVE READ THE ABOVE AGREEMENTS AND FULLY UNDERSTAND THEM

SIGNATURE_____DATE_____

Cornerstone Health and Family Practice

Contact Information

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of personal health information to the minimum necessary to accomplish the intended purpose.

I wish to be contacted in the following manner (circle all that apply)

HOME TELEPHONE: ( )_____

1. OK to leave message on machine with detailed information

3. OK to leave with the following person:_____

2. Leave message with call back number only

WRITTEN COMMUNICATION

1. OK to mail to my home address

2. OK to fax to this number ( )_____

WORK TELEPHONE ( )_____

1. OK to leave message with detailed information

2. Leave message with call back number only

**In case that you are not able to come and pick up prescription at our office, please list the name of the person(s) that are allowed to pick up prescriptions for you. Keep in mind that a picture I.D is required for pick-up.

_____, _____, _____

Signature_____Date_____

Patient Name _____Date of Birth_____

Name of Parent or Legal guardian_____Relation:_____

CORNERSTONE HEALTH AND FAMILY PRACTICE
REVIEW OF PRIVATE POLICIES

_____ I have reviewed the notice of privacy policies and wish to Have a copy.

_____ I have reviewed the notice of privacy policies and do not Wish to have a copy.

_____ _____

Signature of patient or legal guardian Date

Cornerstone Health and Family Practice
2828 N. Stone Ave.
Tucson, AZ 85705
(520) 622 - 4580

Patient Name_____ Date:_____

Insurance Information:

Please make sure of the following:

**If you have more than one insurance you must provide that information
WE must know which insurance is primary

** If you insurance is through someone else make sure date of birth
And social security number is provided

If our office receives a denial for the above reasons
Our office will bill you and you will be responsible for payment to our office
It will become your responsibility to handle the issue with your insurance company.

_____
Patient Signature/Representative

CORNERSTONE HEALTH AND FAMILY PRACTICE
REVIEW OF SYMPTOMS

PLEASE CIRCLE ALL THAT APPLY TO YOUR HEALTH

My weight has changed My sleep has changed Fever

Change in Moles on my skin Rash Change in voice Headaches

Shortness of breath wheezing Cough Chest pain

Irregular Heartbeat swelling in my feet and ankles

Breast lumps Nipple discharge Vaginal discharge Change in my period

Abdominal pain Nausea Vomiting Constipation

Heartburn Bloody stools Blood in my urine It burns to urinate

I urinate more frequently than usual I sometimes lose control of my urine

I have impotence I sometimes have trouble getting or maintaining erection

I bruise easy I have heat or cold intolerance My joints hurt

My muscles hurt I have numbness My vision has changed

I'm often depressed I have anxiety I have thoughts of suicide

I smoke I drink I take street drugs

Name_____ DOB_____Date_____

CORNERSTONE HEALTH & FAMILY PRACTICE

NEW PATIENT MEDICAL HISTORY

Patient Name_____Age:_____Date_____

What medications are you allergic to? _____

Please list all medications that you take and the dosage. Include all over – the counter medications, vitamins and herbal medication _____

_____

What surgeries have you had and when: _____

_____

Do you smoke? _____ If yes, how many cigarettes or packs per day? _____

Do you drink alcohol? _____ If yes, how many drinks per week? _____

Do you use street drugs? _____ If so, what kind? _____

Do you work? _____ What kind of work do you do? _____

Who do you live with? _____

When was your last PAP? _____ last Mammogram? _____

When was your last Colonoscopy? _____

DO YOU HAVE FAMILY HISTORY OF:

Heart attack? _____yes_____no If yes, what family member? _____

Stroke? _____yes_____no If yes, what family member? _____

Cancer? _____yes_____no If yes, what family member? _____

Where was the cancer located? _____

Diabetes _____yes_____no If yes, what family member? _____

Asthma? _____yes_____no If yes, what family member? _____

Clotting disorder _____yes_____no If yes, what family member? _____

High Blood Pressure? _____yes_____no If yes, what family member? _____

Do you have a Medical Power of Attorney? _____yes _____no Living Will _____yes _____no

We offer a combined Power of Attorney/Living Will, would you like to make one_____ yes _____ no