Patient Update

Primary Physician_____

Patient Name_____ DOB_____ Sex___ Race_____ Ethnicity Latino/Hispanic Other
Marital Status
School _____ Grade_____ (Parents of child): ☐Married ☐Divorced ☐Separated ☐ Never Married ☐ Widowed

Patient Address_____Zip Code_____

Dad's Name_____ DOB_____ SSN_____

Mom's Name_____ DOB_____ SSN_____

Dad's Email_____ Mom's Email_____

Step Dad's Name_____ DOB_____ SSN_____

Step Mom's Name_____ DOB_____ SSN_____

Child resides with_____

Other address if parents not in same household:_____
Whose address is this_____

Please list phone numbers in order you prefer us call you. (mom cell 1st, home 2nd, dad cell 3rd, work, etc.)
#1._____ ☐ mom cell ☐ home ☐ dad cell ☐ _____ #2._____ ☐ mom cell ☐ home ☐ dad cell ☐ _____
#3._____ ☐ mom cell ☐ home ☐ dad cell ☐ _____ #4._____ ☐ mom cell ☐ home ☐ dad cell ☐ _____

Please check all processes in which our office can remind you of upcoming appointments:
☐VOICE ☐TEXT ☐EMAIL

Dad's Employer_____ Work Phone_____
Mom's Employer_____ Work Phone_____

Emergency Contact other than parents_____ Phone_____

List all children that should be under the same account:

Name	DOB	Sex	Race	Ethnicity	School Attends

PREFERRED PHARMACY (name and location)_____

INSURANCE INFORMATION:

Primary Insurance Co_____ Insured's Name_____DOB___ Group No._____ Contract No._____

Secondary Insurance Co_____ Insured's Name_____DOB___ Group No._____ Contract No._____

I hereby authorized payment directly to the physician of the surgical and/or medical benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims. A $45 reschedule fee may apply for well child checkups rescheduled on the same day. There may be a $45 no show fee if an appointment is not kept.

_____ _____
Signature Date

Updated: 121422

ADDITIONAL PERSON FOR RELEASE OF INFORMATION

Patient Name_____ DOB_____

Patient Name_____ DOB_____

Patient Name_____ DOB_____

Patient Name_____ DOB_____

Patient Name_____ DOB_____

Patient Name_____ DOB_____

Purpose: To ensure authorization that releases Cornerstone Pediatrics to speak with additional persons regarding patient care.

I, _____, parent/guardian of the above listed children, authorize the following individuals to be able to discuss my child(ren's) care and/or appointments at Cornerstone Pediatrics with the physicians, clinical staff, as well as the front office staff.

_____		_____	
Name	Relationship	Name	Relationship
_____		_____	
Name	Relationship	Name	Relationship
_____		_____	
Name	Relationship	Name	Relationship
_____		_____	
Name	Relationship	Name	Relationship

X_____ _____

Signature of Parent/Guardian Date