Patient Registration

☐New Patient
☐Established Patient Update

Patient Information

Patient's Full Name _____ ☐ Male ☐ Female

Social Security # _____ Date of Birth _____

Home Address _____

City _____ State: _____ Zip :_____

Home Phone _____ Primary Language _____

Signature _____ Date _____
*Signature Here Allows Us To Leave Messages at the Numbers Listed Above Via Voicemail, Person, Etc.

List of Siblings

Name: _____ ☐ Male ☐ Female Date of Birth _____

Name: _____ ☐ Male ☐ Female Date of Birth _____

Name: _____ ☐ Male ☐ Female Date of Birth _____

Parent / Guardian Information 1		Parent / Guardian Information 2	
Name		Name	
Date of Birth	☐ Male ☐ Female	Date of Birth	☐ Male ☐ Female
Social Security Number		Social Security Number	
Address		Address	
City, State, Zip		City, State, Zip	
Occupation		Occupation	
Employer		Employer	
Home Phone		Home Phone	
Work Phone		Work Phone	
Cell Phone		Cell Phone	
Email		Email	
Relationship to Patient		Relationship to Patient	
Marital Status	☐ Married ☐ Single ☐ Widowed ☐ Divorced	Marital Status	☐ Married ☐ Single ☐ Widowed ☐ Divorced

Guarantor / Responsible Party _____

In case of separated or divorced parents,
Who is the custodial parent? _____

Primary Insurance Information

*****Please Provide Your Insurance Card to the Receptionist*****

☐ Americhoice ☐ Amerigroup ☐ TennCare Select ☐ Blue Cross Blue Shield ☐ Tricare
☐ United Healthcare ☐ Cigna ☐ Aetna ☐ Blue Care ☐ Other Insurance _____

Insurance Company _____ Insurance Phone # _____

Insured / Card Holder's Name _____ Date of Birth _____ Social Security # _____

Policy Number _____ Group Number _____ Effective Date of Insurance _____

Secondary Insurance Information

*****Please Provide Your Insurance Card to the Receptionist*****

☐ Americhoice ☐ Amerigroup ☐ TennCare Select ☐ Blue Cross Blue Shield ☐ Tricare
☐ United Healthcare ☐ Cigna ☐ Aetna ☐ Other Insurance _____

Insurance Company _____ Insurance Phone # _____

Insured / Card Holder's Name _____ Date of Birth _____ Social Security # _____

Policy Number _____ Group Number _____ Effective Date of Insurance _____

Emergency Contact - OTHER THAN PARENT

Name of Contact _____ ☐ Male ☐Female

Full Address _____

_____ City State Zip

Home Phone: _____ Cell Number: _____ Work Number: _____

Relationship to Child ☐ Grandparent ☐ Aunt / Uncle ☐ Step Parent ☐ Friend ☐ Other

Were You Referred to Cornerstone Pediatrics By Another Doctor? Y N Doctor's Name

_____

Other Person(s) Allowed to Bring Patient to the Office

Name of Contact _____ ☐ Male ☐ Female

Full Address _____

_____ City State Zip

Home Phone: _____ Cell Number: _____ Work Number: _____

Relationship to Child ☐ Grandparent ☐ Aunt / Uncle ☐ Step Parent ☐ Friend ☐ Other

Authorization to pay benefits to Physician: I hereby authorize payment directly to the physician of the physician group of the medical benefits. If payments are paid to me for his/her services as described, I understand that I must pay the physician group. Furthermore, I am responsible to pay non-covered services. I also authorize the release of information by the physician and the release information acquired in the course of my treatment that is necessary to process insurance claims.

_____ _____

Signature (Parent/Guardian) Date

*Signature Here Allows Us To Leave Messages at the Numbers Listed Above Via Voicemail, Person, Etc..