

Cornerstone Health Services

Almont Family Practice • Cornerstone Specialists • Eastside Family Care • Garfield Family Practice • Lakeview Pediatrics • New Baltimore Family Practice
Pointe Family Physicians • Romeo Family Practice • Romeo Plank Diagnostic Center • Romeo Plank Family Medical Center • Schoenherr Family Practice

PLEASE PRINT Today's Date _____

Patient Name: Last _____ First _____ M.I. _____ Soc. Sec. # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Date of Birth _____ Marital Status _____ Sex _____
M F

Responsible party for Patient's Bills _____

Employed by _____ Business Phone _____

Spouse or Other _____
Parent (if minor) _____

Employed By _____ Business Phone _____

If we have scheduled appointment time for you and you are unable to keep this appointment, please give us 24 hours advance notice. Failure to do so may result in a \$25.00 Missed Appointment Charge.

If you wish to avoid a \$5.00 Service Charge for billings, we request that our charges be paid at the conclusion of each visit.

— COPY FRONT & BACK OF INSURANCE CARD —

INSURANCE NAME _____ Phone _____

Contract Number _____ Group _____

Service or Benefit Code _____ Effective Date _____

Subscriber _____ Subscriber Date of Birth _____

— INSURANCE RELEASE —

I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby certify that I have provided my complete insurance information. I also understand it is my responsibility to notify Cornerstone Health Services when any change occurs with my insurance coverage.

I request payment of authorized Medicare, Blue Cross or independent insurance benefits be made either to me or on my behalf to Cornerstone Health Services for any services furnished me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for the related services.

Date _____ Signed _____

INSURED OR AUTHORIZED PERSON

IN CASE OF EMERGENCY: Nearest relative or friend not living with you:

Name _____ Relationship _____

Address _____

City _____ State _____ Zip Code _____ Phone _____

How did you hear about our office? _____

AFFILIATED WITH

