Cornerstone Family Care, PC

2750 Clay Edwards Drive • Suite 612 •
North Kansas City, MO 64116
Phone: (816) 221-7744 • Fax: (816) 221-7755

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name (Last, First, Middle Initial)	Date of Birth	Social Security #
Address	Sex	Marital Status
City, State, Zip	Home Phone	Todays Date
Primary Employer	Work Phone	Cell Phone
Employer's Address	City, State, Zip	
Emergency Contact: Name, Relationship	Emergency Contact Phone #	

Follow My Health Patient Portal: Please Provide Email Address for Access: _____

_____ Contact Phone _____ _____ Alternate Phone _____

_____ Work Phone _____

What Pharmacy do you use: (Please include street name or city)

PATIENT DEMOGRAPHICS – Please Check Where Applicable

Employment Status _____ Full-time _____ Part-time Student _____ YES _____ NO ___ Full-time ___ Part-time

Retired _____ YES _____ NO | Veteran or Current Military Status: _____ YES _____ NO

Race: _____ White _____ Asian _____ Native Hawaiian or Other Pacific Islander

_____ Black or African American _____ American Indian _____Other _____Decline

Ethnicity: _____ Hispanic or Latino _____ Non-hispanic or Latino _____ Unknown _____ Decline

PATIENT REGISTRATION FORM

****PLEASE NOTE THAT ALL CO-PAYS ARE DUE AT THE TIME OF SERVICE, THANK YOU****

PRIMARY INSURANCE INFORMATION

Name Of Primary Insurance Company	Policy #/ID#	
Name of Policy Holder	Group #	
Relationship of Policy Holder to Patient	Co-Pay Amount	
Address of Insurance Company	Insured Social Security #	Insured Date of Birth
City, State, Zip	Effective Date	Expiration Date

SECONDARY

Name Of Secondary Insurance Company	Policy #/ID#	
Name of Policy Holder	Group #	
Relationship of Policy Holder to Patient	Co-Pay Amount	
Address of Insurance Company	Insured Social Security #	Insured Date of Birth
City, State, Zip	Effective Date	Expiration Date

PLEASE ATTACH A COPY OF INSURANCE CARD – IF NO COPY IS AVAILABLE, THE ACCOUNT WILL BE CONSIDERED "SELF-PAY

Medical Authorization: The undersigned permits the physicians and all other personnel caring for the patient to examine, recommend treatment, and explain any associated risk involved. The undersigned also understands that this care may include diagnostic testing, examinations, or surgical treatment and no guarantees have been made regarding the outcome of this care.

Financial Agreement: I, the undersigned agree to be responsible for the balance of my account. Although an insurance claim (if applicable) will be filed with my insurance company by Cornerstone Family Care on my behalf, negotiating payments through my insurance company is ultimately my obligation. I understand that payment will be made at the time of services rendered unless financial arrangements have been made PRIOR to the services. A statement will be mailed to me showing the balance due from me and will be considered past due after 30 days. If I am unable to make payment in full, I understand that I should contact the business office immediately to set up a payment arrangement. I understand that if no payment has been received or financial arrangements made on my balance, my account may be sent to collections. If my account is referred for collections, I understand that I will be responsible for the balance as well as any fees associated with the collection process.

Signature DATE