



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	Today's 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

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**\*\*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

**WE REQUIRE THE ACTUAL INSURANCE CARD - IF NO INSURANCE CARD IS AVAILABLE, THE ACCOUNT WILL BE "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