NEW PT REG
CORNERSTONE HEALTH AND FAMILY PRACTICE
PATIENT INFORMATION

Last Name:_____First Name:_____Middle initial_____

Social Security #_____Date of Birth:_____/_____/_____Marital Status_____

Address:_____City:_____State_____Zip_____
_

Home Phone#:_____Cell#:_____Message #:_____

Spouse Name:_____Cell#_____Work:_____

Emergency Contact:_____Relationship:_____Phone:_____

Address:_____City:_____State:_____Zip:_____
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INSURANCE INFORMATION
Is insurance thru an employer? _____Company Name: _____

Employee Name:_____Social Security #_____DOB:_____

Insurance Name:_____ID#:_____Group#:_____

Is this a work or accident related injury?_____Date of Injury:_____

CONDITIONS OF FINANCIAL AGREEMENT
The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient he/she hereby individually obligates himself to pay the account of Dr. Shawn G. Platt, D.O in accordance with the regular rates and terms. Should the account be referred to a collection agency, the undersigned shall pay reasonable collections

SIGNATURE_____DATE:_____
(Parent or Legal Guardian)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGMENT OF BENEFITS
Thereby authorize Dr. Shawn G. Platt, D.O to release medical information to my insurance company concerning treatment of the above name patient while under care, and further authorized payment of any insurance benefits for medical or surgical services to Shawn G. Platt, D.O.

I HAVE READ THE ABOVE AGREEMENTS AND FULLY UNDERSTAND THEM

SIGNATURE_____DATE_____
(Parent or Legal Guardian)