Today's Date: __________

CORNERSTONE MEDICAL CLINIC

Dr. Phelps

825 N. Main Street · Harrison, AR 72601 · 870-743-4900

PLEASE COMPLETE and REVIEW ALL PAGES

Patient Information

Social Security Number: ________/______/____________ **Date of Birth:** _________/_______/_______________

Patient's Last Name: ____________________________ **First Name:** ________________________ **MI:** _______

Mailing Address: ____

City: ____ **State:** ________________ **Zip:** _________________

Gender (Circle One): Male Female

Marital Status (Circle One): Single Married Divorced Widowed Separated

Race (Circle One): Caucasian African American Latino/Hispanic Asian American Indian Refused to Report

Other Race: __________________________________

Ethnicity (Circle One): Non-Hispanic Hispanic Refuse to Report

Preferred Language: ________________________ **Second Language:** ___________________________

May we or our representative/contractors/agents contact you by voice call, voice message, test message, email, or auto call by the following ways? (Circle Yes or No)

Home Phone # ____ **Yes No**

Cell Phone # ____ **Yes No**

Work Phone #____ **Yes No**

Patients Employment (Circle One): Full-Time Part-Time Not Employed Self Employed Retired

Employer Name: ____

Employer Address: ____

Employer Phone: _________________________ **Length of Employment:** __________ Years _____________ Months

Do you want access to your online health records? Yes No

If yes, please include email address.

Email: ____

Emergency Contact: ______________________________ **Phone#** _____________________________

Patient Name: ____ **DOB:** ______________________________

Today's Date: __________

GUARANTOR INFORMATION

Guarantor/Financially Responsible Person: ____

Guarantor Address: ____**SSN:** ______________________

City: __________________________ **State:** _____________ **Zip:** _______________ **DOB:** _____________________

Guarantor Phone: ____

Guarantor Place of Employment: ____

City: ____ **State:** _____________ **Zip:** _______________

Guarantor Employer Phone: ____

Guarantor Position/Title: _____________________________________ **Length of Employment:** ____ **Yrs** ______ **Mo**

Patients Relationship to Guarantor (Circle One): SELF SPOUSE CHILD OTHER (SPECIFY):

____

List other family members in household that come to this clinic:

First and Last Name: ____ DOB _________________

First and Last Name: ____ DOB _________________

First and Last Name: ____ DOB _________________

First and Last Name: ____ DOB _________________

First and Last Name: ____ DOB _________________

PRIMARY Insurance Company Name: ____

ID #: ____ **Group #:** ___________________________

Subscriber/Name on Insurance Card: ____

Subscriber DOB: _______________________ **Subscriber SS#:** ______________________________

SECONDARY Insurance Company Name: ____

ID #: ____ **Group #:** _____________________________

Subscriber/Name on Insurance Card: ____

Subscriber DOB: _______________________ **Subscriber SS#:** ______________________________

It is YOUR responsibility to ensure that we have ALL of your CURRENT insurance information. Failure to provide us with ALL of your information may cause timely filing issues, resulting in your insurance not paying. We file you insurance as a courtesy, but ultimately, payment is your responsibility. Please notify us of any changes to your health insurance coverage.

FOR OFFICE USE ONLY. Insurance card received by :___________ Information entered by:_______________

FORM 04000: Office Policy/Patient Information Acknowledgement. **Verified By:** _________

FORM 06004: Insurance Benefit/Information Release. **Verified By:** _________

FORM 08001-1: Privacy Practices Acknowledgement. **Verified By:** _________

Today's Date: __________

Patient's Name: ____ Date of Birth: ____________

Local Pharmacy: _________________________________ City: ___________________________

Local Pharmacy Phone #: ____

Mail Order Pharmacy Name: ____

Mail Order Phone/Fax Number's: ____

Referring or previous physician: ____

Address/Phone #: ____

Reason for today's visit: ____

____

Please complete the following information to the best of your ability so that we can provide complete and comprehensive care to you. Please explain any "YES" answers. The information submitted will become part of your medical record and is completely confidential.

Allergies: (Medication, Foods, Environmental, etc.)

Allergen:	Reaction:
___________________	____
___________________	____
___________________	____
___________________	____

Immunizations: Are you up to date on your immunizations? Yes ______ No _______

Year of last: Tetanus _____ Pheumovax _____ Flu ______

Hepatitis B _____ Gardasil _____ Meningococcal _____

Family History:

Relative	Health Problems	Age	If deceased, cause of death
Mother	_______________________	______	_______________________
Father	_______________________	______	_______________________
Sibling	_______________________	______	_______________________
Sibling	_______________________	______	_______________________
Sibling	_______________________	______	_______________________
Sibling	_______________________	______	_______________________
Child	_______________________	______	_______________________
Child	_______________________	______	_______________________
Child	_______________________	______	_______________________
Child	_______________________	______	_______________________
Maternal Grandma	_______________________	______	_______________________
Maternal Grandpa	_______________________	______	_______________________
Paternal Grandma	_______________________	______	_______________________
Paternal Grandpa	_______________________	______	_______________________
Other	_______________________	______	_______________________

Today's Date: __________

Patient Name: ____ **DOB:** _____________________________

Anyone in the family with a family history of:

Colon Cancer:	Yes ___	No ___	Whom: ________________________
Ovarian Cancer:	Yes ___	No ___	Whom: ________________________
Uterine Cancer:	Yes ___	No ___	Whom: ________________________
Breast Cancer:	Yes ___	No ___	Whom: ________________________
Diabetes:	Yes ___	No ___	Whom: ________________________
Hypertension:	Yes ___	No ___	Whom: ________________________
Heart Disease:	Yes ___	No ___	Whom: ________________________
Stroke:	Yes ___	No ___	Whom: ________________________

Past Medical History (Please indicate the year this started or occurred)

_____ Alcohol/Substance Abuse
_____ Anemia
_____ Anxiety
_____ Asthma
_____ Blood Transfusion
_____ Cancer (Type:________________)
_____ Chickenpox
_____ Colon Polyps
_____ Congestive Heart Failure
_____ Depression
_____ Diabetes
_____ Eating Disorder (Type:____________)
_____ HIV or exposure
_____ Seizures
_____ Gallbladder Disease
_____ Glaucoma
_____ Gout
_____ Heart Attack
_____ Heart Disease
_____ Hepatitis (Type:____________)
_____ High Blood Pressure
_____ High Cholesterol
_____ Kidney Disease
_____ Lung Disease (COPD)
_____ Migraines
_____ Seasonal Allergies
_____ Osteoporosis
_____ Pneumonia
_____ Psoriasis
_____ Radiation Therapy
_____ Sexually Transmitted Disease
_____ Sinusitis
_____ Sleep Problems
_____ Stomach Ulcer
_____ Stroke / TIA
_____ Thyroid Disease
_____ Tuberculosis
_____ Blood Clots

Other not listed above:

____

Past Surgical History:

_____ Adenoidectomy
_____ Appendectomy
_____ Arthroscopy
(Body Part: _______________)
_____ Biopsy of (____________)
_____ Bowel/Colon Surgery
_____ Joint Surgery/Replacement
(Body Part:_______________)
_____ C-Section
_____ D&C
_____ Gallbladder Removal
_____ Heart Surgery
_____ Hemorrhoidectomy
_____ Hernia Repair
_____ Removal of Ovary(ies)
_____ Tubal Ligation
_____ Hysterectomy
_____ Cataract
_____ Pacemaker
_____ Mastectomy / Lumpectomy
_____ PE Tubes (Ear Tubes)
_____ Tonsillectomy
_____ Oral Surgery
_____ Other

Today's Date: __________

Patient Name: ____ **DOB:** _____________________________

GYN History:

Age at first menstrual period _________________
Are you periods regular? Yes ________ No _______
How many days between each period? _________
How many days do you bleed? ________________
Are your periods light, moderate or heavy? _______
Do you have clots? Yes ______ No ______
What was the first day of your last menstrual period? __________
When was your last pap smear? ___________
Have you ever had an abnormal pap smear? Yes _______ No _______
If yes, what was done? ______________________________________
Have you ever had a sexually transmitted disease? Yes _____ No _____
If yes, what kind? ____

OB History:

How many pregnancies have you had (including any miscarriages or abortions? _____
How many children have you given birth to? _______

	Year	How far along?	Delivery Type	Complications	Birth Weight
1st Pregnancy					
2nd Pregnancy					
3rd Pregnancy					
4th Pregnancy					
5th Pregnancy					
6th Pregnancy					
7th Pregnancy					
8th Pregnancy					
9th Pregnancy					

Today's Date: __________

Patient Name: ____ **DOB:** ____________________________

Social History:

Are You: Single _____ Married _____ Divorced _____ Widowed _____ Minor _____
Occupation: ____
Where do you currently live: City __________________________ State ___________
Do you smoke or chew tobacco? Yes _________ No _________
If yes: How much per day? __________________ For how long? _________________
Have you ever used tobacco? Yes __________ No ___________
When did you start? __________________ When did you stop? __________________
Do you drink alcohol? Yes ____________ No ______________
If yes, how often? ________________ How much? ________________
Do you use any illegal drug? Yes __________ No _____________
If yes, what kind? ____
Do you own pets? Yes ___________ No _______________
If yes, what kind? ____

Travel History:

Have you traveled outside the country in the past 5 years? Yes ________ No ________
If yes, where ____
____

Medications:

Medicine	Amount	Times per Day
____________________________	_________	_____________________________
____________________________	_________	_____________________________
____________________________	_________	_____________________________
____________________________	_________	_____________________________
____________________________	_________	_____________________________
____________________________	_________	_____________________________
____________________________	_________	_____________________________
____________________________	_________	_____________________________
____________________________	_________	_____________________________

Over the counter medicines (herbs, vitamins, diet pills, etc): ___________________________________
____
____

Today's Date: __________

Patient Name: ____ **DOB:** _____________________________

Health Review (last 3 months):

	Yes	No
General:		
Weight change, greater than 5 lbs?	__________	__________
Persistent fatigue?	__________	__________
Skin:		
Any new skin rashes, lumps or bumps?	__________	__________
Hot flashes?	__________	__________
Eyes:		
Recent vision changes?	__________	__________
Mouth:		
Sore throat?	__________	__________
Sore mouth?	__________	__________
Neck:		
New lumps?	__________	__________
Thyroid problems?	__________	__________
Lungs:		
Cough?	__________	__________
Shortness of breath?	__________	__________
Heart:		
Chest Pain?	__________	__________
Even been told you had a heart murmur?	__________	__________
Abnormal EKG?	__________	__________
Gastrointestinal:		
Nausea or vomiting?	__________	__________
Constipation?	__________	__________
Change in bowel habits?	__________	__________
Change in appetite?	__________	__________
Any liver or colon problems?	__________	__________
Genitourinary:		
Problems with urination?	__________	__________
Vaginal dryness?	__________	__________
Joints/Extremities:		
Any bone or joint pain or stiffness?	__________	__________
Arm swelling/lymph edema?	__________	__________
Neurological:		
Have you ever had a seizure?	__________	__________
Do you have weakness of an arm, leg or other part of your body?	____	__________
Blood:		
Any history of anemia or blood disorder?	__________	__________
Psychological:		
Have you ever been treated for depression or anxiety?	__________	__________

Today's Date: __________

Patient Name: ____ **DOB:** ____________________________

Form 04000: Patient Acknowledgment of Receipt of Office Policy and Patient Information

My signature below indicates that I have been given a copy of Cornerstone Medical Clinic's Office Policy and Patient Information. An electronic copy of this form may also be found on our website at www.cornerstonemedicalclinic.com

Form 06004: Insurance Benefits and Information Release

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by me.

I understand that I am responsible for any charges not covered by my insurance for myself or my dependents. I understand that I may be billed by an outside source for charges that may occur outside of our office as a result of tests being sent out to be finalized (including but not limited to radiology, pathology, or laboratory).

Form 08001-1: Patient Acknowledgment of Receipt of Confidentiality of Patient Medical Records Policy/HIPAA Privacy Practices

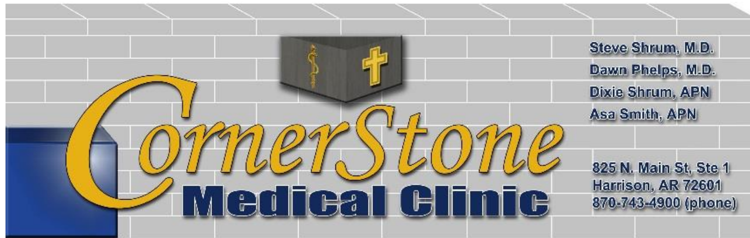
My signature below indicates that I have been given a copy of Cornerstone Medical Clinic's Confidentiality of Patient Medical Records Policy/HIPAA Privacy Practices. An electronic copy of this form may also be found on our website at www.cornerstonemedicalclinic.com

Patient Signature: ____

(parent or guardian's signature if patient is a minor)

Date: ___________________________________

Today's Date: __________



Steve Shrum, M.D., FAAP, FACP
Board Certified Internal Medicine and Pediatrics

Dawn Phelps, M.D
Obstetrics & Gynecology

Dixie Shrum, APN--Pediatrics

Asa, Smith, APN--Family

Medical Records Release of Information

Patient's Name ____

Date of Birth _____________________________________ Social Security Number _________-______-________

The undersigned hereby authorizes and requests medical records to be released **TO**:

Physician/Provider Name: Dr. Shrum Dr. Phelps Dixie Shrum, APN Asa Smith, APN

At Cornerstone Medical Clinic **Phone Number**: 870-743-4900

Address 825 N Main Street, Ste. 1 City, State, and Zip Harrison, AR 72601 **Fax:** 870-743-4949

FROM: Dr.__________________________________ at____
Physician's name Clinic, Hospital, or Facility name

____ __________________________,___________ ____________
Mailing address City State Zip Code

____ ____________________________________
Phone number Fax number

____ Complete Medical Records
____ Office Notes and Diagnostic Data for clinic dates from ____________ to ______________.

This information will be used for ___ Transfer of Care (Released from above practice) ___Referral/Specialists Care
____ Other, Please Specify____

I understand that my medical records may include HIV, psychiatric, alcohol or drug abuse information. This information may be protected by federal and state regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g., probation, parole, etc.) and that in any event this consent expires automatically as described below. If you do not want certain portions of your medical records released, please initial the information you do not want released. ___Substance Abuse ___Psychological/Psychiatric Treatment ___ HIV/AIDA/STD ___Genetic Information

SPECIFICATIONS OF THE DATE, EVENT, OR CONDITION UPON WHICH THIS CONSENT EXPIRES (if left blank this consent expires one year from the date executed)

Executed this _______day of _____________ 20____ ____
(**Patient's signature**)

____ ____
(Witness) (Signature of parent, guardian, or Authorized Representative)