CORNERSTONE MEDICAL CLINIC

Dr. Steve Shrum   Dixie Shrum, APN   Jennifer Martin, APN   Desiree' Looper, APN
825 N. Main Street, Suite 1 · Harrison, AR 72601 · 870-743-4900

PLEASE COMPLETE ALL PAGES   **TODAY'S DATE: ___________________________**

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: ________

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, text 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**

Emergency Contact: ____ **Phone#:** ________________________________

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? (Circle one): Yes No

If yes, please include email address. Email: ____

FOR OFFICE USE ONLY.
PPWK/Insurance card received on: _________________ *by* ______ *Reviewed by::* _______ *Information entered by:* ______
Appointment Date: _____________ *Provider:* __________ *Record Release faxed to previous provider on:* ________ *by:* _____
OP/HIPAA Entered by: __________

Patient Name: ____ **DOB:** ____________________

GUARANTOR INFORMATION

Guarantor/Financially Responsible Person: ________________________________ **DOB:** ____________________

Address: ____ **Guarantor SSN:** ________________________

City: ____ **State:** ________ **Zip:** ____________________

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 your insurance as a courtesy, but ultimately, payment is your responsibility. Please notify us of any changes to your health insurance coverage.

Patient's Name: ____ Date of Birth: ____________

Local Pharmacy: ____ City: ___________________________

Local Pharmacy Phone #: ____

Mail Order Pharmacy Name: ____

Mail Order Phone/Fax Number's: ____

Previous physician or referring 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.

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

___	Alcohol / Substance Abuse	___	Epilepsy / Seizures	___	Migraines / Headaches
___	Allergies	___	Gallbladder / Gall stones	___	Mumps
___	Anemia	___	Glaucoma	___	Osteoporosis
___	Asthma	___	Gout	___	Pneumonia
___	Bleeding Tendency	___	Heart Attack / Bypass	___	Psoriasis
___	Blood Transfusion	___	Heart Pacemaker	___	Radiation Therapy
___	Body Piercing / Tattoos	___	Heart Problems - Other	___	Rheumatic Fever
___	Cancer (Type:___________)	___	Heart Valve	___	Scarlet Fever
___	Chicken Pox	___	Hepatitis (Type:________)	___	Seasonal Allergies
___	Colon Disease	___	HIV or exposure	___	Sexually Transmitted Disease
___	Colon Polyps	___	High Blood Pressure	___	Sinusitis
___	Congestive Heart Failure	___	High Cholesterol	___	Sleep Problems
___	Depression / Anxiety	___	Epilepsy / Seizures	___	Stomach Ulcer
___	Diabetes	___	Inflammatory Bowel Disease	___	Stroke / TIA
___	Diphtheria	___	Kidney Disease	___	Thyroid Disease
___	Diverticulitis	___	Kidney Stones	___	Tuberculosis
___	Eating Disorder	___	Lung Disease (COPD)	___	Sexually Transmitted Disease

Other not listed above: ____

Illnesses Requiring Hospitalization: ____

____

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

Allergen:	**Reaction:**
______________________	____
______________________	____
______________________	____
______________________	____
______________________	____
______________________	____

Patient Name: ____ **DOB:** ______________________

Family History: Please list which relative (mother, father, brother, sister, maternal grandmother, paternal grandfather, etc.) Remember to include problems such as those listed in Past Medical History) (**BE SPECIFIC, SUCH AS IRREGULAR HEARTBEAT, TYPE OF CANCER & WHICH RELATIVE)**

Illness	**Relative(s)** Maternal or Paternal	**Illness**	**Relative(s)** Maternal or Paternal
Diabetes		Hay Fever	
Arthritis		Eczema	
Cancer (type)		Bleeding Disorder	
Heart Disease		Other:	
High Blood Pressure			
Kidney Disease			
Asthma			

Have any of your blood relatives died before the age of 60? Yes _____ No _____
If yes, please explain: ____

Medications:

Medicine	**Dose**	**Reason**	**Year Started**	**By Dr.**
________________________	__________	____________________________________	______	______________
________________________	__________	____________________________________	______	______________
________________________	__________	____________________________________	______	______________
________________________	__________	____________________________________	______	______________
________________________	__________	____________________________________	______	______________
________________________	__________	____________________________________	______	______________
________________________	__________	____________________________________	______	______________
________________________	__________	____________________________________	______	______________
________________________	__________	____________________________________	______	______________
________________________	__________	____________________________________	______	______________
________________________	__________	____________________________________	______	______________
________________________	__________	____________________________________	______	______________

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

Patient Name: ____ **DOB:** _____________________________

Social History

FOR PATIENTS *OLDER* THAN 18 YEARS:

Tobacco History: Current tobacco user? _____ Type: __________ How much: __________ How long: _____

Former tobacco user? _____ When did you quit? _____________________________________

Never used tobacco. ______

Do you drink alcohol? _____ Type: ____________________ How Much: ____________ How Long: ________

Do you use recreational drugs? ______ Type? ___________ How Much: ____________ How Long: ________

Do you get regular exercise? ______ Type? _______________________________ How Often: _____________

Highest Level of Education Completed (High School, College, Degrees): _____________________________________

Occupation: ____

Foreign Travel (Location and year): ____

Military Experience (Branch and Years): ____

Spouse / Partner's Name: ____

Child or Children's Name(s) and Age(s): ____

Who lives at home: ____

Religion / Church: ____

FOR PATIENTS *UNDER* 18 YEARS OLD:

Tobacco History: Current tobacco user? _____ Type: __________ How much: __________ How long? _____

Former tobacco user? _____ When did you quit? _____________________________________

Never used tobacco. ______ Birth Weight: ______________ Birth Height: ________________

Delivery: Vaginal / C-section If C-Section (circle): Emergency or Elective

How many weeks gestation: _______ How many days until discharged home? ______

Complications of labor / delivery (i.e., Infections, Breech delivery, Twin): __________________________________

____

Breastfed (Duration, how often): ____

Formula (Type, amount, and how often): ____

Solids introduced (If yes, then describe): ____

Immunizations up to date? Yes / No

Mom / Dad's Name and Date of Birth: ____

Dad's employment: ____

Mom's employment: ____

Who lives at home: ____

Religion / Church: ____

School / Daycare: ____

Foreign Travel: ____

Smokers at home (inside or outside): ____

Patient Name: ____ **DOB:** ______________________________

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
(Type: _______________________)
_____ Tubal Ligation

_____ Hysterectomy
_____ Cataract
_____ Pacemaker
_____ Mastectomy / Lumpectomy
_____ PE Tubes (Ear Tubes)
_____ Tonsillectomy
_____ Removal of Ovary(ies)
_____ Vasectomy

Other Surgery: ____

Previous Tests: (X-rays, CAT scans, Ultrasounds, EKGs, Echo-cardiograms, Colonoscopy, EGD, Arteriogram, Lung Tests, Etc.)
____
____
____

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					

Patient Name: ____ **DOB:** _________________________________

Review of Systems: (Please describe any "yes" answers)

Please check if these have occurred in the past month:

	Yes	No
General:		
Appetite change	___	___
Chills	___	___
Fatigue	___	___
Fever	___	___
Night sweats	___	___
Sleeping problems	___	___
Weight gain	___	___
Weight loss	___	___
Head:	___	___
Headaches	___	___
Lumps or bumps	___	___
Eyes:	___	___
Double vision	___	___
Dry eyes	___	___
Glasses	___	___
Glaucoma	___	___
See spots	___	___
Worsening vision	___	___
Ears:	___	___
Hearing loss	___	___
Infections	___	___
Ringing (Tinnitus)	___	___
Nose:	___	___
Allergies	___	___
Bleeding	___	___
Sinusitis	___	___
Throat:	___	___
Sore Throat	___	___
Hoarseness	___	___
Voice Changes	___	___
Respiratory:	___	___
Asthma or wheeze	___	___
Cough	___	___
Cough up blood	___	___
Cough up phlegm	___	___
Pleurisy	___	___
Shortness of breath	___	___

Please check if these have occurred in the past month:

	Yes	No
Cardiovascular:		
Angina	___	___
Chest Pain	___	___
Chest Tightness	___	___
Exertional leg pain	___	___
Fluttering	___	___
Palpitations	___	___
Smothering	___	___
Swelling	___	___
Gastrointestinal:	___	___
Belching	___	___
Black stools	___	___
Blood in stool	___	___
Blood in vomit	___	___
Change in stool	___	___
Constipation	___	___
Diarrhea	___	___
Difficulty Swallowing	___	___
Food intolerance	___	___
Heart Burn	___	___
Jaundice	___	___
Nausea	___	___
Vomiting	___	___
Neurological:	___	___
Dizziness	___	___
Headaches	___	___
Numbness	___	___
Passed out	___	___
Shakes or tremor	___	___
Seizure	___	___
Genitourinary:	___	___
Blood in urine	___	___
Can't start stream	___	___
Can't hold urine	___	___
Frequent urination	___	___
Genital discharge	___	___
Nighttime urination	___	___
Painful urination	___	___
Testicular pain	___	___

Please check if these have occurred in the past month:

	Yes	No
Musculoskeletal:		
Back pain	___	___
Neck pain	___	___
Joint pain	___	___
Sprains or strains	___	___
Swollen joint(s)	___	___
Metabolic:	___	___
Cold intolerance	___	___
Constantly drink	___	___
Constantly urinate	___	___
Heat intolerance	___	___
High blood sugar	___	___
Low blood sugar	___	___
Psychiatric:	___	___
Anxiety	___	___
Cry often	___	___
Depression	___	___
Family problems	___	___
Guilt	___	___
Hot flashes	___	___
Memory loss	___	___
Mental slowing	___	___
Mood swings	___	___
Suicidal thoughts	___	___
Work problems	___	___
Worry a lot	___	___
Skin:	___	___
Bumps	___	___
Hair changes	___	___
Rash	___	___
Hematological:	___	___
Bleeds easy	___	___
Bruises easily	___	___
Blood clot	___	___
	___	___
Women:	___	___
Nipple discharge	___	___
Vaginal discharge	___	___
Vaginal dryness	___	___

825 N. Main Street, Suite 1
Harrison, AR. 72601
Phone 870-743-4900
Fax 870-743-4949

Cornerstone Medical Clinic, PLLC

Patient Acknowledgement of Receipt of Office Policy and Patient Information, Confidentiality of Patient Medical Records Policy, HIPAA Privacy Practices, Insurance Benefits, and Information Release

Patient Name: ______________________________________ DOB: ___________________

- My signature below indicates that I have been given a copy of Cornerstone Medical Clinic's Office Policy and Patient Information, as well as the Confidentiality of Patient Medical Records Policy/HIPAA Privacy Practices. An electronic copy of these forms may also be found on our website at www.cornerstonemedicalclinic.com
- I hereby authorize the physician to release 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 because of tests being sent out to be finalized (including but not limited to radiology, pathology, or laboratory).
- My signature below indicates that I have authorized Cornerstone Medical Clinic, and its employees, contractors, and/or associates to allow access, give information, or inform regarding my health records and/or account activity to the following individuals:

NAME OF INDIVIDUAL(s):	**RELATIONSHIP TO PATIENT:**
1)______________________________________	______________________________
2)______________________________________	______________________________
3)______________________________________	______________________________
4)______________________________________	______________________________

Patient Signature: _______________________________________ Date: ___________________
(Parent or guardian's signature if patient is a minor)

825 N Main Street, Suite 1

Harrison, AR 72601

(870)743-4900 phone

Steve Shrum, M. D.
Board Certified Internal Medicine
Board Certified Pediatrics

Dixie Shrum, P.N.P.
Board Certified Pediatric Nurse Practitioner

Jennifer Martin, F.N.P.
Board Certified Family Nurse Practitioner

Desiree' Looper, F.N.P.
Board Certified Family Nurse Practitioner

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: Steve Shrum, M.D. Dixie Shrum, APN Jennifer Martin, FPN Desiree' Looper, FNP

At: Cornerstone Medical Clinic
825 N. Main Street, Suite 1
Harrison, AR. 72601

Phone: 870-743-4900

Fax: 870-743-4949

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

Address: ____ City: __________________ State: ______ Zip: __________

Phone: ____ Fax: ____

_______ 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)

Today's date: _______________________ Patient Signature: ____

Signature of Parent, Guardian, or authorized representative: ____