

CORNERSTONE MEDICAL CLINIC

Dr. Steve Shrum Dixie Shrum, APN Asa Smith, APN Jennifer Martin, APN
825 N. Main Street, Suite 1 • 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, 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

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: _____

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 Acknowledgment. Verified By: _____

FORM 06004: Insurance Benefit/Information Release. Verified By: _____

FORM 08001-1: Privacy Practices Acknowledgment. Verified By: _____

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.

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

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

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
1 st Pregnancy					
2 nd Pregnancy					
3 rd Pregnancy					
4 th Pregnancy					
5 th Pregnancy					
6 th Pregnancy					
7 th Pregnancy					
8 th Pregnancy					
9 th Pregnancy					

Past Surgical History:

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

Other Surgery: _____

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

Patient Name: _____ DOB: _____

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

Please check if these have occurred in the past month:

Please check if these have occurred in the past month:

Please check if these have occurred in the past month:

	Yes	No		Yes	No		Yes	No
General:			Cardiovascular:			Musculoskeletal:		
Appetite change	___	___	Angina	___	___	Back pain	___	___
Chills	___	___	Chest Pain	___	___	Neck pain	___	___
Fatigue	___	___	Chest Tightness	___	___	Joint pain	___	___
Fever	___	___	Exertional leg pain	___	___	Sprains or strains	___	___
Night sweats	___	___	Fluttering	___	___	Swollen joint(s)	___	___
Sleeping problems	___	___	Palpitations	___	___			
Weight gain	___	___	Smothering	___	___	Metabolic:	___	___
Weight loss	___	___	Swelling	___	___	Cold intolerance	___	___
						Constantly drink	___	___
Head:	___	___	Gastrointestinal:	___	___	Constantly urinate	___	___
Headaches	___	___	Belching	___	___	Heat intolerance	___	___
Lumps or bumps	___	___	Black stools	___	___	High blood sugar	___	___
			Blood in stool	___	___	Low blood sugar	___	___
Eyes:	___	___	Blood in vomit	___	___			
Double vision	___	___	Change in stool	___	___	Psychiatric:	___	___
Dry eyes	___	___	Constipation	___	___	Anxiety	___	___
Glasses	___	___	Diarrhea	___	___	Cry often	___	___
Glaucoma	___	___	Difficulty Swallowing	___	___	Depression	___	___
See spots	___	___	Food intolerance	___	___	Family problems	___	___
Worsening vision	___	___	Heart Burn	___	___	Guilt	___	___
			Jaundice	___	___	Hot flashes	___	___
Ears:	___	___	Nausea	___	___	Memory loss	___	___
Hearing loss	___	___	Vomiting	___	___	Mental slowing	___	___
Infections	___	___				Mood swings	___	___
Ringing (Tinnitus)	___	___	Neurological:	___	___	Suicidal thoughts	___	___
			Dizziness	___	___	Work problems	___	___
Nose:	___	___	Headaches	___	___	Worry a lot	___	___
Allergies	___	___	Numbness	___	___			
Bleeding	___	___	Passed out	___	___	Skin:	___	___
Sinusitis	___	___	Shakes or tremor	___	___	Bumps	___	___
			Seizure	___	___	Hair changes	___	___
Throat:	___	___				Rash	___	___
Sore Throat	___	___	Genitourinary:	___	___			
Hoarseness	___	___	Blood in urine	___	___	Hematological:	___	___
Voice Changes	___	___	Can't start stream	___	___	Bleeds easy	___	___
			Can't hold urine	___	___	Bruises easily	___	___
Respiratory:	___	___	Frequent urination	___	___	Blood clot	___	___
Asthma or wheeze	___	___	Genital discharge	___	___			
Cough	___	___	Nighttime urination	___	___	Women:	___	___
Cough up blood	___	___	Painful urination	___	___	Nipple discharge	___	___
Cough up phlegm	___	___	Testicular pain	___	___	Vaginal discharge	___	___
Pleurisy	___	___				Vaginal dryness	___	___
Shortness of breath	___	___						

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: _____

Patient Health Literacy Measures
Brief (Three) Screening Questions for Health Literacy:

PLEASE CIRCLE RESPONSE FOR EACH QUESTION.

1. How often do you have problems learning about your medical condition because of difficulty understanding written information?

1-Never

2-Occasionally

3-Sometimes

4-Often

5-Always

2. How often do you have someone help you read hospital materials?

1-Never

2-Occasionally

3-Sometimes

4-Often

5-Always

3. *How confident are you filling out medical forms by yourself?

1-Extremely

2-Quite a bit

3-Somewhat

4-A little

5-Not at all

Patient Name: _____

DOB: _____



Steve Shrum, M. D.
and Board Certified Internal Medicine
Pediatrics
Dawn Phelps, M.D.
Obstetrics & Gynecology

Dixie Shrum, P.N.P.

Asa Smith, F.N.P.

825 N. Main St Ste A 870-743-4900 Phone
Harrison, AR 72601 870-743-4949 Fax
F.N.P.

Jennifer Martin,

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, FPN Jennifer Martin, FPN

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/AIDS/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)