Today's Date: _____

CORNERSTONE MEDICAL CLINIC

Dr. Steve Shrum; Dixie Shrum, APN.; Rana Burnside, 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, 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#** _____

Today's Date: _____

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 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.

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
___ Diverticulosis	___ 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:**
_____	_____
_____	_____
_____	_____
_____	_____

Today's Date: _____

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)

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): _____
_____
_____

Today's Date: _____

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? _____ Birth Weight _____ Birth Height _____

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? _____

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): _____

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					

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, Echocardiograms, Colonoscopy, EGD, Arteriogram, Lung Tests, Etc.)

_____
_____
_____

Today's Date: _____

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 easliy	___	___
Blood clot	___	___
	___	___
Women:	___	___
Nipple discharge	___	___
Vaginal discharge	___	___
Vaginal dryness	___	___

Explain:_____

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: _____

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

Dawn Phelps, M.D.
Obstetrics & Gynecology

Dixie Shrum, P.N.P.

Rana Burnside, F.N.P.

Steve Shrum M.D.
Dawn Phelps, M.D.
Dixie Shrum, APN
Rana Burnside, APN

CornerStone Medical Clinic

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

cornerstonemedicalclinic.com

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 Rana Burnside, 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

AR SHARE (State Health Alliance for Records Exchange) Email Address: dlange@direct.sharearkansas.org

FROM: Dr._____ at_____
Physician's name Clinic, Hospital, or Facility name

_____ _____,_____ _____
Mailing address City State Zip Code

_____ _____ _____
Phone number Fax number SHARE (State Health Alliance for Records Exchange) Address

____ 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)

Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500, in the case of a first offense, and not more than $5000 in the case of each subsequent offense.