

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, 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# _____

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 your 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 _____ Pneumovax _____ 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	_____	_____	_____

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

Other not listed above:

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	___ Removal of Ovary(ies)	___ Oral Surgery
(Body Part: _____)	___ Tubal Ligation	___ Other

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Patient Name: _____ DOB: _____

GYN History:

Age at first menstrual period _____
Are your 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					

Today's Date: _____

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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): _____

Patient Name: _____ DOB: _____

Health Review (last 3 months):

General:	Yes	No
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?	_____	_____

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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.
Board Certified Internal Medicine and Pediatrics

Dawn Phelps, M.D.
Obstetrics & Gynecology

Dixie Shrum, P.N.P.

Rana Burnside, F.N.P.

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/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)

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.