

New Patient Information

First: _____ Middle _____ Last: _____

DOB: _____ ☐ Male ☐ Female Preferred Name: _____

Preferred Language: _____

Circle One: White African American Native American Hispanic Asian/Pacific Islander Other

Parent/Guardian #1 (This will be listed as primary contact, phone number, and address unless otherwise indicated)

Full Name: _____ DOB: _____

Relationship to Patient: _____

Address: _____

Email: _____

Primary Phone (____) _____ Secondary (____) _____

SSN: _____

Parent/Guardian #2

Full Name: _____ DOB: _____

Relationship: _____

Address: _____

Email: _____

Primary Phone (____) _____ Secondary (____) _____

SSN: _____

Primary Insurance

Name of insured: _____ Insured DOB: _____

Relationship: _____

Insurance Company: _____ I.D. Number: _____

Group #: _____

Secondary Insurance (If applicable)

Name of insured: _____ Insured DOB: _____

Relationship: _____

Insurance Company: _____ I.D. Number: _____

Group #: _____

Preferred Pharmacy _____

Previous PCP: _____

How did You Hear About Us?: _____ Birth State: _____

Form Completed by: _____



Cornerstone Pediatrics, PLLC
259 E. 141st St. Glenpool, OK 74033
Phone: (918) 771-8771 Fax: (918) 553-0356

Patient Medical history

Name: _____ DOB: _____

Form completed by: _____

Allergies		Reaction Type
Medications		
Foods		
Environmental		

Birth history			
Birth Weight: ____ lbs ____ oz		Weeks Gestation: ____ weeks ____ days	
Vaginal or C-Section	IF C-Section, reason?		
Induction? YES NO	If Yes Explain:		
Complications with pregnancy? YES NO If Yes Explain:			
Medications Taken During Pregnancy:			Passed Hearing Screen? YES NO
In Utero Exposure to Drugs/Alcohol/Nicotine/Marijuana? YES NO			Birth Facility:
NICU? YES NO If Yes Explain:			
Birth Hep B Received? YES NO		Vitamin K Received? YES NO	Circumcision (if male) YES NO

Past Medical History							
Please mark Yes or No for each condition listed, and the age at time of initial diagnosis.							
	Yes	No	Age		Yes	No	Age
ADHD				Cancer			
Anxiety/Depression				Seizures			
Autism				Stroke			
Heart Murmur				Failed vision screen			
Concussion				Failed hearing screen			
Diabetes				Eczema			
Ear Infections				Asthma/Reactive Airway			

Please List Any Surgeries:

_____ Date: _____ Surgeon/Hospital: _____
_____ Date: _____ Surgeon/Hospital: _____
_____ Date: _____ Surgeon/Hospital: _____

Please List Any Overnight Hospitalizations:

_____ Date: _____ Hospital: _____
_____ Date: _____ Hospital: _____
_____ Date: _____ Hospital: _____

Social history

Does Child live with both biological Parents? ☐ YES ☐ NO

If no, Please Explain: _____

Does Child Attend Day Care or Mother's Day Out? ☐ YES ☐ NO

If yes, Where? _____

School Attending: _____ Grade: _____

Does anyone Smoke Inside the Home? ☐ YES ☐ NO

Any history of physical, emotional, or sexual abuse? ☐ YES ☐ NO

Has Child been in DHS Custody? ☐ YES ☐ NO

Pets In Home ☐ YES ☐ NO If Yes, What Kind: _____

Anything else you want your provider to know? _____

Family history

Please list ALL: Biological Parents, Siblings,
Maternal Grandparents, Paternal Grandparents

Name	DOB	Relationship	Health Problems (diabetes, asthma, heart disease, stroke, genetic conditions, clotting/bleeding disorders, hypertension, etc).

Medical Home Agreement

Child's Name: _____ DOB: _____

Your healthcare is a team approach involving both you and your PCP

Your Medical Home PCP is responsible for:

1. Honoring your rights as a patient and treating you with dignity and respect.
2. Listening to your concerns, educating you on your health care needs and preventive services.
3. Treating you as a whole person: physically, mentally, and emotionally.
4. Providing you with ongoing quality, and safe medical care, including prevention of future health complications.
5. Working to schedule timely office appointments for your chronic and urgent healthcare needs.
6. Being available to you 24 hours a day, by office appointment, phone calls and/or other electronic communication.
7. Providing you with other healthcare resources when they are absent or unavailable.
8. Providing you with referrals to specialists as deemed medically necessary by your PCP.
9. Providing you with treatment, medications, equipment, and any other resources deemed medically necessary by your PCP.

As a Medical Home Patient, you are responsible for:

1. Working with your PCP to meet all of your health care needs.
2. Communicating with your PCP about all your healthcare concerns and goals.
3. Reporting any changes related to your health, treatments, medications, etc. This includes use of all medications - prescription, over-the-counter, herbal and street drugs.
This also includes any medical equipment being used or that has been ordered or recommended for use.
4. Calling your PCP before going to the Emergency Room, unless it is life threatening.
5. Notifying your PCP after any Emergency Room, Urgent Care Clinic or Hospital visit.
6. Scheduling medical appointments in a timely manner, including follow-up appointments.
7. Keeping appointments as scheduled with your PCP and any appointments scheduled with a specialist.
8. Calling before your appointment time to cancel or reschedule the appointment as soon as you are aware that you will not be able to make the appointment.
9. Understanding that you may be dismissed from your PCP if you repeatedly miss appointments without notice or do not follow the responsibilities listed in the medical home agreement.

Guardian Signature: _____ Date: _____

Provider Signature: _____ Date: _____



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Guardian consent for sharing Protected health information (PHI)

I, _____, give Cornerstone Pediatrics, PLLC permission to speak with the following people regarding my child's health information. This includes authority permission to discuss payment for health services received from Cornerstone Pediatrics, PLLC. I understand that sharing health information with specialists and other health providers is necessary and not excluded by this form. This form gives Cornerstone Pediatrics, PLLC permission to share health information with non-professionals such as extended family members should I desire.

Please Note: Legal guardian(s) and biological parents are entitled to all medical information unless otherwise specified by court order. You must provide our office with an up-to-date copy.

This consent is valid until I provide Cornerstone Pediatrics, PLLC with written revocation.

Patient's Name: _____ Date of Birth: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

(____) **NO ONE EXCEPT PARENT(S) OR LEGAL GUARDIAN(S)**

Guardian Signature: _____ Date Effective: _____



No-Show & Late Arrival Policy

At Cornerstone Pediatrics, PLLC we understand that everyone's time is valuable. However, missed appointments impact the flow of patients in our clinic. To ensure that patients are seen in a timely manner, we have adopted a No-Show and Late Arrival Policy. This policy ensures that Cornerstone Pediatrics, PLLC can provide high-quality, timely, patient-centered care. Details of our policy are defined below:

- No-show: You don't arrive for your appointment, and you don't reach out to cancel.
- Late arrival: You arrive 15 or more minutes past your scheduled appointment time.
- No Show Fee: If you no-show your appointment and do not contact our office by the end of the business day, you may be charged a \$25 fee that must be paid before an appointment can be rescheduled.
- Dismissal: If no-show appointments are deemed "excessive" then Cornerstone Pediatrics, PLLC reserves the right to dismiss patient and sibling(s).
- Reschedule: Understand, that if you arrive 15 or more minutes after your appointment time, you may be asked to reschedule your appointment to another date/time.

Please contact our office if you need to reschedule or know that you will be arriving after your appointment time. We appreciate your cooperation and understanding.

I have read and examined the above information and understand the terms as listed.

Child's Name: _____ DOB: _____

Guardian Signature: _____ Date: _____

Financial Policy

Thank you for choosing Cornerstone Pediatrics, PLLC. Your understanding of our Practice Financial Policy and payment for services are important parts of a provider-patient relationship. Please review the information below, if you need further information regarding any of our policies, please speak to our staff.

- **When are payments due?** All copayments, deductibles, patient responsibility amounts, cash-pay amounts, and past-due balances are due at the time of check-in unless previous arrangements have been made.

- **How may I pay?** We accept payment by cash, check, and major cards.

- **Will you bill my insurance?** Insurance is a contract between you and your insurance company. We will bill your primary insurance company. To properly bill your insurance company, we require that you disclose all insurance information, including primary and secondary insurance. It is your responsibility to notify our office of any changes. Failure to provide complete and accurate insurance information may result in the entire bill being categorized as a patient's responsibility.

- **What if my insurance is out of network?** If we are not a provider under your insurance plan, you may be responsible for payment in full at the time of service.

- **Which plans do you contract with?** Cornerstone Pediatrics, PLLC accepts most major insurance plans. However, with the frequent changes that happen in the insurance marketplace, it is a good idea for you to contact your insurance company prior to your appointment and verify if we are a participating provider as per your plan.

I understand the above policies and understand my financial responsibility.

Child's Name: _____ DOB: _____

Guardian's Name: _____ DOB: _____

Authorization to Release Patient health Information

Patient

Patient Name (First, Middle, Last)

Date of Birth

Obtain From:

Name of Organization

Street Address

City, State, Zip

Phone

Fax

Release To:

Cornerstone Pediatrics

Name of Organization

259 E 141st St. Glenpool, OK 74033

Street Address City, State, Zip

918-771-8771

Phone

918-553-0356

Fax

Information to be Released

☐ All Medical Records ☐ Immunization Records ☐ Other: _____

☐ Medical Records from ___/___/___ to ___/___/___

Purpose of Release

☐ Transfer of Care ☐ Legal ☐ Personal Use ☐ Other: _____

Authorization for General Release of Information

I understand that:

- Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form to assure treatment or payment.
- I can cancel this authorization at any time by providing written notice to Cornerstone Pediatrics, PLLC. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.
- This authorization will expire 90 days from the date signed below, unless otherwise noted.

Signature

Signature of Patient or Legal Guardian

Date

Printed Name of Patient or Legal Guardian

Relationship to Patient