CORNERSTONE
MEDICAL CENTER

New Patient Paperwork

Basic Information

Name:_____ **DOB:** _____

Address: _____ **Zip**_____

Phone Number: _____**Email:** _____

SSN:_____ **Sex (circle):** M F Other

Marital Status (circle): Single Married Divorced Widowed

Race (circle): White Hispanic/Latino American Indian/Alaskan Native Asian Black/African Native Hawaiian/Other Pacific Islander Other

Patient Information:

Parent/Legal Guardian Name: _____
(If under the age of 18)

Insurance Name:_____ **Member ID #:**_____

Emergency Contact Name: _____

Emergency Contact Phone: _____ **Relationship:** _____

Primary Care Provider: _____

Pharmacy: _____

Current Living Situation: _____**Employer:** _____
(stable home, homeless, with family, multi-family)

Highest Level of Education: _____

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Medical History

Allergies:

_____

_____

Current Medications:

_____

_____

_____

_____

Medical Conditions:

_____

_____

_____

_____

Past Surgical History:

_____

_____

_____

_____

Date of Last Menstrual Cycle (if applicable): _____

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Father Medical History:

_____

_____

Mother Medical History:

_____

_____

Sibling's Medical History:

_____

_____

Substance Use

Alcohol (circle): Y N Occasionally

Tobacco (circle): Y N Occasionally

Marijuana (circle): Y N Occasionally

Vape (circle): Y N Occasionally

Caffeine (circle):

Y N Occasionally

If yes, what kind? _____

Other Recreational Drug Use (circle):

Y N Occasionally

If yes, what kind? _____

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MEDICAL CENTER

MEDICAL RECORDS RELEASE FORM

Patient Information:

Name: _____ DOB: _____ Phone: _____

Address: _____

Release Records FROM:

Name/Facility: _____

Address: _____

Phone: _____ Fax: _____

Release Records TO:

Name/Facility: Cornerstone Medical Center

Address: 1004 E. Main St, Cortez, CO 81321

Phone: 970-564-3363 Fax: 970-788-7365

Information to Be Released:

☒ Complete Record ☐ Visit Notes ☐ Labs ☐ Imaging ☐
Medications ☐ Immunizations ☐ Billing ☐ Treatment Records
☐ Other: _____

Purpose of Release:

☒ Continuity of Care ☐ Insurance ☐ Legal ☐ Personal ☐ Employment
☐ Other: _____

Authorization:

I authorize the release of my health information as indicated. I understand this is voluntary and may be revoked in writing at any time, except where action has already been taken. This authorization expires **12 months** from signing unless specified:_____. I understand released records may not remain protected by HIPAA once disclosed.

Signature: _____ **Printed Name:** _____

Date:_____

If representative: ☐ Parent ☐ Guardian ☐ POA ☐ Other:

Witness (optional) _____