NEW PATIENT REFERRAL FORM

Phone: 972-798-8001
Fax: 972-798-8002
Email: Intake@cornerstone-hc.com
Website: www.cornerstone-hc.com

Referral Source: _____ **Date:** ____/____/____

Contact Name: P: _____ **F:** _____

PATIENT NAME *(LAST)*: _____ *(FIRST)*: _____ *(MI)*: _____

ADDRESS: _____ **APT/BLDG #**: _____

CITY: _____ **STATE**: _____ **ZIP**: _____ - _____

❑ *HOME* ❑ *APARTMENT* ❑ *DOMICILIARY* **NAME OF FACILITY/APT**: _____

PATIENT PHONE: _____ **IS THIS THE NUMBER TO CALL WHEN MAKING APPTS**: ❑ *YES* ❑ *NO*

PATIENT EMAIL: _____

SSN: _____ **DATE OF BIRTH**: _____ **GENDER**: ❑ *MALE* ❑ *FEMALE*

MARITAL STATUS: ❑ *SINGLE* ❑ *MARRIED* ❑ *WIDOWED* ❑ *DIVORCED* **NAME OF SPOUSE**: _____

IN THE EVENT OF AN EMERGENCY CONTACT: _____

RELATION TO PATIENT: _____ **PHONE**: _____

DOES THE PATIENT HAVE A POA/GUARDIAN: ❑ *YES* ❑ *NO (SKIP THIS SECTION)* **LEGAL STATUS**: ❑ *POA* ❑ *GUARDIAN*

NAME: _____ **RELATIONSHIP**: _____

ADDRESS: _____ **APT/BLDG #**: _____

CITY: _____ **STATE**: _____ **ZIP**: _____ - _____

POA/GUARDIAN PHONE: _____ **NOTIFY BEFORE EACH VISIT**: ❑ *YES* ❑ *NO*

PATIENT DX/HEALTH ISSUES: _____

SPECIAL VISIT INSTRUCTIONS: _____

IS THE PATIENT LATEX SENSITIVE: ❑ *YES* ❑ *NO* **IS THE PATIENT CURRENTLY BEING TREATED BY A PRIMARY PHYS**: ❑ *YES* ❑ *NO*

IS THE PATIENT CURRENTLY ON OR RECEIVING: ❑ *HOSPICE* ❑ *HOME CARE* ❑ *AIDE SERVICES* ❑ **OTHER**: _____

NAME OF AGENCY PROVIDING SERVICES: _____ **PHONE**: _____

MEDICARE: _____ **EFFECTIVE DATE**: _____ **HMO INVOLVEMENT**: ❑ *YES* ❑ *NO*

PART B ELIGIBLE: ❑ *YES* ❑ *NO* **OPEN MSP**: ❑ *YES* ❑ *NO* **VERIFICATION**: ❑ *C-SNAP* ❑ *PHONE*

MEDICAID *(IF APPLICABLE)*: _____ **EFFECTIVE DATE**: _____ **HMO INVOLVEMENT**: ❑ *YES* ❑ *NO*

OTHER INSURANCE CARRIER *(IF APPLICABLE)*: _____

POLICY NUMBER: _____ **GROUP NUMBER**: _____

TYPE OF POLICY: ❑ *HMO* ❑ *PPO* ❑ *TRADITIONAL* ❑ *PFFS* **PHONE**: _____