

Cornerstone Family Practice
10001 South Eastern Avenue, Suite 309 • Henderson, Nevada 89052
Tel: (702) 269-6345 • Fax: (702) 269-9422

PATIENT REGISTRATION

Date _____
Patient Name _____ () Male () Female Date of Birth _____
SS# _____ Martial Status: () Single () Married () Divorced () Other

Address _____
Street Apt. # City State Zip

Phone _____
Home Work Cellular

Responsible Party Name and Phone Number _____

Responsible Party Date of Birth _____ Social Security # _____

Responsible Party Address _____
City State Zip

Emergency Contact _____ Relationship _____ Phone _____

Patients Employer _____ Do you have Insurance through your employer? () Yes () No

If the patient is a student, is he/she a : () Full Time Student () Part Time Student

How did you hear about our office? ___ YELLOW PAGES ___ NEWSPAPER ___ FRIEND
___ PROVIDER BOOK ___ REFERRAL ___ OTHER _____

Pharmacy Name _____ Address _____ Phone Number _____

COORDINATION OF BENEFITS

Please list below your current primary insurance. **IF YOU ARE COVERED BY A MEDICAID PROGRAM, YOU MUST GIVE THIS OFFICE ANY INSURANCE INFORMATION YOU MAY HAVE THROUGH AN EMPLOYER.**

Primary Insurance _____

Insurance Phone # _____

Insurance Co. Address _____

City _____ ST _____ Zip _____

Name of Insured _____

Relationship to Patient _____

Insured DOB _____ SS# _____

ID#/SS # _____

Group # _____

Insured Employer _____

Insured Work Phone _____

Employer Address _____

City _____ ST _____ Zip _____

Secondary Insurance _____

Insurance Phone # _____

Insurance Co. Address _____

City _____ ST _____ Zip _____

Name of Insured _____

Relationship to Patient _____

Insured DOB _____ SS# _____

ID#/SS # _____

Group # _____

Insured Employer _____

Insured Work Phone _____

Employer Address _____

City _____ ST _____ Zip _____