CORNERSTONE FAMILY MEDICINE

Chad A. Griffin, MD Anna Benningfield, APN, Kelly Lyons, APN Laura Goff, FNP

Patient Name: _____ **Date:** _____

Address: _____ **City:** _____ **ST**_____ **Zip**_____

Gender: (Please Circle) Male Female

Sexual Orientation: (Please Circle) Heterosexual Homosexual Other Choose not to disclose

Date of Birth: _____ **Marital Status:** (Please Circle) Married Single Widowed Divorced

Race: (Please Circle) White Black Asian Bi-Racial **Ethnicity:** (Please Circle) Hispanic Non-Hispanic

Preferred Language: (Please Circle) English Spanish Other: (Please Specify) _____

SSN: ___-___-___

Home Phone: _____ **Work:** _____ **Cell Phone:** _____

Email Address: _____

Do you consent to receive emails for communication from our office: (Please Circle) Yes No

Preferred Contact Method: (Please Circle) Home Phone Cell Phone Email

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Responsible Party: (If patient is a minor)

Name: _____ **Date of Birth:** _____

Phone Number: _____ **Relationship to Patient:** _____

EMERGENCY CONTACT

Name: _____ **Date of Birth:** _____

Phone Number: _____ **Relationship to Patient:** _____

Please Specify to Whom We May Release Your Records

Name	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____

Do you have a living will? (Please Circle) Yes No **Do you have a POA?** (Please Circle) Yes No

Signature: _____ **Date:** _____