12371 Cottage Woods Drive
Ashland, VA 23005
804.363.7214 804.798.5279 (fax)

New Patient Information Form

Child's Name: First_________________________ Last________________________________ Middle Initial________

Child's Date of Birth __________________________ Male________ Female_________

Child's Primary Care Physician Name____ Phone____________________

Diagnosis of your child__________________________ Physician's Name/Phone_________________________________

Parent or Guardian Name: First_____________________ Last_________________________ Middle Initial______

Parent or Guardian Name: First_____________________ Last_________________________ Middle Initial______

Street Address ____ Home Phone______________________

City, State, Zip ____ Cell Phone_________________________

Email____

Person Responsible for Bill____

Street Address (if different from above)____

City, State, Zip____

Occupation__________________ Employer_____________________________________ Work Phone______________

Primary Insurance ________________________ Policyholder Name_____________________ Date of Birth__________

ID Number____ Group Number__________________________________

Insurance Phone Number____ Card Date___________________________

Secondary Insurance (if applicable)____

ID Number____ Group Number__________________________________

Insurance Phone Number____ Card Date___________________________

Chose Cornerstone Because/Referred by____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. **Payments are due within 30 days of receipt of invoice**. I also authorize Cornerstone and/or my insurance company to release any information required to process my claims. This form also authorizes Cornerstone to treat my child as needed based on evaluations and therapist recommendations.

Signature____ Date_________________________________