

Patient Information				
Name (Last, First, Middle)		SSN#	DOB	Sex
Mailing Address		P.O. Box Apartment #		
City, State, Zip		City, State, Zip		
Home Phone	Work/Day Phone	Home Phone	Work/Day Phone	
Email Address:				
Marital Status	Cell Phone #	Student? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Full time <input type="checkbox"/> Part time	Occupation	
Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	Race	Religion	Language	
Primary Care Physician		Primary Care Physician Address		
Is today's visit related to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Other Date of Accident (If applicable): ____/____/____ Body Site Injured: _____ Have you reported injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, to whom? <input type="checkbox"/> Employer <input type="checkbox"/> Auto Insurance Company <input type="checkbox"/> Police <input type="checkbox"/> Other:				
Referral Resource: <input type="checkbox"/> Advertisement <input type="checkbox"/> Friend/Relative <input type="checkbox"/> Phone Book <input type="checkbox"/> Website				

Employer			
Primary		Secondary Employer	
Address		Address	
City, State, Zip		City, State, Zip	
Work #	Ext.	Work #	Ext.

**** All Returned Checks are subject to a \$25.00 Check Fee****

I authorize the release of any medical or other information necessary to process claims. I also authorize Government Benefits to the provider who accepts assignment and authorize payment to the physician or supplier for the services provided. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the information on this form and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

X _____
 Signature of Patient/Guardian

 Date

Guarantor (Responsible Party Information)				
Name (Last, First, Middle)		SSN #	DOB	Sex
Local Address		Secondary Address		
City, State, Zip		City, State, Zip		
Home Phone	Work/Day Phone	Home Phone	Work/Day Phone	

Insurance Card #1	
Insurance Card Name	Policy Number
Policy Through Employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Policy Holder's Name
Employer Name	Policy Holder's DOB
Employer Address	Policy Holder Retired <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer Phone #	Date Of Retirement
Patient Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	

Insurance Card #2	
Insurance Card Name	Policy Number
Policy Through Employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Policy Holder's Name
Employer Name	Policy Holder's DOB
Employer Address	Policy Holder Retired <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer Phone #	Date Of Retirement
Patient Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	



155 Crystal Run Road
Middletown, NY 10941

845•703•6999
www.crystalrunhealthcare.com

Assignment of Benefits

Date: _____

Patient's Name: _____

Date of Birth: _____

I consent to examination and treatment by the physicians and nursing staff of Crystal Run Healthcare.

I request that payment of authorized Medical Insurance, Workers Compensation, No-Fault or Medicare benefits be made on my behalf to Crystal Run Healthcare LLP for services furnished to me by the provider.

I authorize Crystal Run Healthcare to release any and all of my medical records, including but not limited to: records of office visits and treatment rendered, clinical laboratory reports, diagnostic test results, x-ray reports, videotapes and photographs.

Such records may be released to my attorney, another physician, or any other health care professional, or facility for the purposes of discussing my condition, consulting on my case, or reviewing my medical records.

These records in their entirety regardless of dates of coverage may be released to any governmental agencies, insurance companies, employees of insurance companies, and the physicians health organizations (PHOs) which contract with my insurer for the purpose of pursuing payment, insurance reimbursement, submitting claims for services rendered or to be rendered to me, or performing quality assurance review as required by law.

Patient Signature _____

Date _____



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Patient Representative Form

Print Name: _____

Date of Birth: _____

Social Security Number: _____ / _____ / _____

Patient Information

This permits Crystal Run Healthcare LLP to allow _____, as designated below, to be present in the examination room, and I give permission to Crystal Run Healthcare, its practitioners, employees and representatives, to share all aspects of my medical care and treatment, and to discuss all payment issues, with such individual(s) *

Representative Information

Name of the Individual: _____

Date of Birth: _____

Address: _____

Telephone #: _____

Relationship to the Patient: _____

**A separate authorization must be completed to share highly sensitive information, such as HIV, alcohol and substance abuse treatment, or mental health information.*

Patient Signature _____ Date _____

Witness _____