Crystal Run Healthcare

155 Crystal Run Road
Middletown, NY 10941
845-703-6999

61 Emerald Place
Rock Hill, NY 12775
845-794-6999

Patient Information

Name (Last, First, Middle)	SSN#: _____ - _____ -_____	
Date of Birth (mm/dd/yy): _____ / _____ /_____	Sex: M F (Circle One)	Marital Status:
Mailing Address	Street Address (if different)	
City, State, Zip	City, State, Zip	
Home Phone	Day Phone	Cell Phone

Preferred method of receiving appointment reminders?

Telephone Call: ☐ Home Phone ☐ Cell Phone

☐ Text Message or ☐ Both Telephone Call & Text Message

Text messaging fees may apply. Speak with a Crystal Run Healthcare representative at any time to change these options.

Email

Race *(Government mandated question)*
☐ American Indian/Alaska native ☐ Asian ☐ Black/African American ☐ White/Caucasian
☐ Other Pacific Islander ☐ Other Race ☐ Decline to answer

Language ☐ English ☐ Spanish ☐ Other, please specify:

Religion	Ethnicity *(Government mandated question)* ☐ Hispanic ☐ Non-Hispanic ☐ Decline to answer
Primary Care Physician	Primary Care Physician Address/Phone
Employer Name	Occupation
Employer City, State, Zip	Employer Phone

Primary Insurance	Secondary Insurance (if applicable)
Payer Name	Payer Name
Policy Number	Policy Number
Policy Holder Retired? ☐ Yes ☐ No	Policy Holder Retired? ☐ Yes ☐ No
Date of Retirement _____ / _____ / _____	Date of Retirement _____ / _____ / _____
Is the patient the policy holder? ☐ Yes ☐ No If **No**, please complete section below:	Is the patient the policy holder? ☐ Yes ☐ No If **No**, please complete section below:
Policy Holder Name	Policy Holder Name
Policy Holder DOB	Policy Holder DOB

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Policy Holder Address	Policy Holder Address
Patient Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other	Patient Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other

Responsible Party (ONLY If patient is under 18 or Legal Dependent)			
Name (Last, First, Middle)	SSN	DOB	Sex
Mailing Address	City, State, Zip		
Home Phone	Day/Work Phone		
Mother's Maiden Name			

Acknowledgment/Authorization

I hereby acknowledge I have received the CRHC Notice of Privacy Practices

I consent to examination and treatment by the physicians and staff of CRHC

I request that payment of authorized Medical, Workers Compensation, No-Fault or Government insurance benefits be made on my behalf to CRHC for services furnished to me by the provider.

I authorize the release of any medical or other information necessary to process claims

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 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

How did you hear about us?

☐ Internet ☐ Radio ☐ Newspaper ☐ Referral