Crystal Run Healthcare
Part of Optum

155 Crystal Run Road
Middletown, NY 10941

845•703•6999
www.crystalrunhealthcare.com

Patient Information

Legal Name (Last, First, Middle)

Preferred Name/Nickname:

Date of Birth (mm/dd/yyyy): ____ / ____ /_____

Birth Sex:
☐ M ☐ F

Current Gender:

Relationship Status:

Gender Identity
☐ Female ☐ Male ☐ Nonbinary ☐ Choose not to disclose
☐ Transgender Female ☐ Transgender Male

Sexual Orientation ☐ Choose not to disclose
☐ Asexual ☐ Bisexual ☐ Pansexual ☐ Straight ☐ Gay or Lesbian
☐ Queer ☐ Something Else ☐ Don't Know ☐ Questioning

Mailing Address

Street Address (if different)

City, State, Zip

City, State, Zip

Home Phone

Cell Phone

Email Address

Emergency Contact

Name:_____Relationship to Patient:_____

Mobile Phone:_____ Home Phone:_____

Race *(Government mandated question)*
☐ Black/African American ☐ White/Caucasian ☐ Unknown ☐ Decline to answer
☐ Other, please specify:

Language *(Government mandated question)*
☐ English ☐ Spanish
☐ Other, please specify:

Ethnicity *(Government mandated question)*
☐ Hispanic ☐ non-Hispanic ☐ Decline to answer
☐Other, please specify:

Primary Care Provider

- If you have a Crystal Run Healthcare PCP, Name:_____
- If you have a PCP outside of Crystal Run, Name:_____

  Practice:_____Address:_____

Guarantor/Responsible Party (ONLY If patient is under 18 or Legal Dependent)

Legal Name (Last, First, Middle)

DOB (mm/dd/yyyy)
___/___/_____

Birth Sex:
☐ M ☐ F

Mailing Address

City, State, Zip

Home Phone Day/Work Phone

Relationship to Patient
☐ Self ☐ Spouse ☐ Child ☐ Other

Acknowledgment/Authorization

- Legal Name is defined as being the complete name on government issued identification or as attesting to on this registration form.
- I certify that this information is true and correct to the best of my knowledge. I will notify CRHC of any changes to the above information.

Signature of Patient/Guardian _____**Date** _____