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

We want you healthy.®
Crystal Run® Healthcare
155 Crystal Run Road
Middletown, NY 10941
845•703•6999
www.crystalrunhealthcare.com

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 discuss all aspects of my medical care and treatment, including, but not limited to my protected health information, and to discuss all payment issues, with such individual(s)* THIS FORM DOES NOT SERVE AS A NEW YORK STATE HEALTH PROXY OR HEALTH CARE POWER OF ATTORNEY

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. THIS DOES NOT GRANT THE PATIENT REPRESENTATIVE THE RIGHT TO ACCESS PRINTED MEDICAL CHARTS OR INFORMATION AND DOES NOT GIVE THEM THE RIGHT TO REQUEST THEM ON THE PATIENT'S BEHALF. In order to revoke the rights of the Patient Representative to discuss or otherwise access your PHI a revocation must be submitted to Crystal Run Healthcare LLP.*

Patient Signature: _____Date: _____

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Family Information Form

Please take a moment to fill out this information form for our records. Your child's health and well being are important to us. Please be advised that we require a parent/legal guardian or authorized care giver (any adult over age 18years) to accompany your child to the office for all appointments. If you (parent/legal guardian) are unable to accompany your child to the office, please ask us for a consent form.

Patient Information

Patients Name: _____ Date of Birth _____

Mothers Name: _____

Fathers Name: _____

Legal Guardian's Name: _____

Members of the Household

Name/Age/Relationship to patient _____

Name/Age/Relationship to patient _____

Name/Age/Relationship to patient _____

Name/Age/Relationship to patient _____

Name/Age/Relationship to patient _____

Name/Age/Relationship to patient _____

Questions

Do the parents listed above have legally joint custody of the child? ☐ Yes ☐ No

If you answered "No" to question 1, please list the name of the legal custodial parent/ guardian. Please provide our office with any custody papers for our records.

Name: _____

Information Form