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

Patient Information

Legal Name (Last, First, Middle)	Date of Birth (mm/dd/yy): ___ / ___ /______
Preferred Name/Nickname	SSN#: *(optional)* _________ - __________ -_________
Birth Sex: M F (Circle One) / Current Gender:	Relationship 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*: ☐ Text Message only 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

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 Legal Name	Policy Holder Legal Name
Policy Holder DOB	Policy Holder DOB
Policy Holder Address	Policy Holder Address
Patient Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other	Patient Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other

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Guarantor/Responsible Party (ONLY If patient is under 18 or Legal Dependent)			
Name (Last, First, Middle)	SSN *(Optional)* _______-________-______	DOB ___ /___ /_______	Birth Sex: M F
Mailing Address	City, State, Zip		
Home Phone	Day/Work Phone		
Mother's Maiden Name			

Acknowledgment/Authorization

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

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

I consent to making my health care information available to other health care providers for treatment purposes.

I authorize and direct CRHC to release to governmental agencies, insurance carriers and others who are financially liable for my medical care, any information necessary to process, or substantiate payment, for my insurance claims.

I hereby assign or transfer to Crystal Run Healthcare the payment of benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my medical care to cover the cost of care and treatment rendered to myself and my dependents. I request that payment of authorized benefits be made on my behalf and I understand, and agree that, regardless of my insurance status, I am ultimately responsible for charges not covered by policy or plan.

I agree that this authorization shall be valid until canceled in writing or replaced with one of a later date. A photocopy of this assignment shall be considered as valid as the original.

I have read all the information above and fully understand the terms thereof.

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.

X____ ____________________________

Signature of Patient/Guardian **Date**