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/yyyy): ____ / ____ /_____
Preferred Name/Nickname:		SSN#: *(optional)* _____ - _____ -_____
Birth Sex: ☐ M ☐ F	Current Gender:	Relationship Status:

Gender Identity
☐ Choose not to disclose ☐ Male ☐ Female ☐ Female-to-Male/Transgender Male
☐ Male-to-Female/Transgender Female ☐ Genderqueer, neither exclusively male nor female
☐ Additional Gender Category

Sexual Orientation
☐ Choose not to disclose ☐ Straight or Heterosexual ☐ Bisexual ☐ Lesbian, Gay or Homosexual ☐ Don't know

Mailing Address	Street Address (if different)
City, State, Zip	City, State, Zip

Home Phone	Cell Phone	Day Phone

Email Address

Communication: Crystal Run Healthcare (CRHC) uses a variety of methods to communicate information to our patients regarding appointment reminders, practice cancellations/closures, patient registration, and overall health information and education. By choosing to accept, you are agreeing to receive communication via phone (including pre-recorded appointment reminder messages and autodialed calls), text message or emails to any of the telephone/cell phone numbers and email address you have provided. The text messages may contain personal health information. Text messaging is not a secure method of communication and carries some risk of being read by a third party. Message and data rates may apply and the message frequency varies.

☐ Accept
☐ Decline (By choosing to decline, you will only receive appointment reminders to the home phone number listed above)

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

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

Ethnicity *(Government mandated question)* ☐ Hispanic ☐ Non-Hispanic ☐ Decline to answer	**Religion** *(Optional)*
Primary Care Physician Name: Address: Phone:	**Employer** Name: Address: Phone:

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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 below:	**Is the patient the Policy Holder?** ☐ Yes ☐ No ***If No***, please complete below:
Policy Holder Legal Name	Policy Holder Legal Name
Policy Holder DOB (mm/dd/yyyy): ____ / ____ /_____	Policy Holder DOB (mm/dd/yyyy): ____ / ____ /_____
Policy Holder Address	Policy Holder Address
Patient Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other	Patient Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other

Guarantor/Responsible Party (ONLY If patient is under 18 or Legal Dependent)			
Legal Name (Last, First, Middle)	SSN *(Optional)* _____-_____-_____	DOB (mm/dd/yyy) ___ /___ /_____	Birth Sex: ☐ M ☐ F
Mailing Address	City, State, Zip		
Home Phone	Day/Work Phone		
Mother's Maiden Name	Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other		

Acknowledgment/Authorization

- I hereby acknowledge that I have received the Optum NJ NY Notice of Privacy Practices.
- I hereby acknowledge that I have received the Patient Code of Conduct and understand I may request a copy.
- 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.
- Legal Name is defined as being the complete name on government issued identification or as attesting to on this registration form.
- 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.

Signature of Patient/Guardian **Date**