(Legal Name) Last Name __________________________ First Name ________________________MI _____Sex (M) (F)

Preferred Name ____

DOB _____/_____/_____SSN _____--_____-______ Marital Status _______ Employer__________________________
Please circle preferred number for contact
Telephone: Home _________________________ Cell _________________________ Work _________________________

Mailing Address ____
(Street) (City) (State) (Zip Code)
Spouse Name ____ DOB _____/_____/_____SSN ______--______-______

Emergency Contact (Not Living with you): Name ___________________________________Phone___________________

Pharmacy ____ City _____________________________________

PATIENT OR GUARDIAN INFORMATION (IF MINOR)

Father's Name ____ DOB _____/_____/_____SSN _____--_____-______

Mailing Address ____
(Street) (City) (State) (Zip Code)
Telephone: Home _______________________ Cell ___________________________ Work ___________________________

Mother's Name ____ DOB _____/_____/_____SSN _____-_____-______

Mailing Address ____
(Street) (City) (State) (Zip Code)

Telephone: Home ________________________ Cell __________________________ Work ___________________________

INSURANCE INFORMATION

Primary Insurance ___________________________________ Policy # ____________________ Group # ______________

Primary Insurance Address ____

Name of Policy Holder _____________________________________ DOB _____/_____/_____SSN _____-_____-______

Relationship to Patient____________________________ Employer ____

Secondary Insurance _________________________________ Policy # ___________________ Group # _______________

Secondary Insurance Address ____

Name of Policy Holder _____________________________________ DOB _____/_____/_____SSN _____--_____-______

Relationship to Patient________________________________ Employer ____

PLEASE INITIAL

________ I authorize treatment of the patient named above and agree to pay all charges for such treatment. I also authorize the release of medical or other information necessary to process health insurance claims, authorize CRHD permission to seek medical records for continuation of care and authorize my insurance benefits to be paid directly to CRHD.

________ I authorize CRHD to contact me at the cell phone number(s) listed above.

________ I acknowledge that I have received, read, understand, and agree to the terms set forth in CRHD's Financial Policy

________ I acknowledge that I have received, read, and understand CRHD's HIPAA Privacy Rule

Patient or Responsible Party____ Date __________________________________