

CASTLE ROCK MEDICAL CENTER
WELCOME TO OUR OFFICE!

===== PATIENT INFORMATION =====

Legal Last Name _____ Legal First Name _____ MI _____
Preferred nickname _____ Gender _____ Ethnicity _____ Email _____
DOB _____ SS# _____ Marital Status _____ Employer _____
Telephone: Home _____ Cell _____ Work _____
Address _____
(Street and mailing address if different) City State Zip
Spouse Name _____ DOB _____ SS# _____
Emergency Contact _____ Relationship _____ Phone _____
Pharmacy _____ City _____

===== PARENT OR GUARDIAN INFORMATION (if minor) =====

Father's Name _____ DOB _____ SS# _____
Address _____
(Street and mailing address if different) City State Zip
Telephone: Home _____ Cell _____ Work _____
Employer _____ Is this person a patient here? _____
Mother's Name _____ DOB _____ SS# _____
Address _____
(Street and mailing address if different) City State Zip
Telephone: Home _____ Cell _____ Work _____
Employer _____ Is this person a patient here? _____

===== INSURANCE INFORMATION =====

Primary Insurance _____ Policy# _____ Group# _____
Primary Insurance Address _____
Policy Holder Name _____ DOB _____ SS# _____
Policy Holder Address _____ Relationship to patient _____ Employer _____
Secondary Insurance _____ Policy# _____ Group# _____
Secondary Insurance Address _____
Name of Policy Holder _____ DOB _____ SS# _____
Policy Holder Address _____ 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 _____