CASTLE ROCK MEDICAL CENTER
WELCOME TO OUR OFFICE!

========== **PATIENT INFORMATION** ==========

Legal Last Name_____ Legal First Name_____ MI_____

Preferred name/nickname_____ Sex (M) (F)_____ E-mail address_____

DOB_____SS#_____Martial 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_____