Mineral Community Hospital Clinic

Health Care for Your Family

"This institution is an equal opportunity provider"

PATIENT'S INFORMATION Date _____ Time _____

Patient Name _____ DOB _____

Mailing Address _____

Physical Address _____

Phone Number _____ ☐ Home ☐ Cell ☐ Message

Other Phone Number _____ ☐ Home ☐ Cell ☐ Message

Marital Status _____ Gender: ☐ M ☐ F

Race: ☐ Caucasian ☐ Hispanic ☐ African American ☐ Native American ☐ Other

SSN _____ Ethnicity: ☐ Hispanic/Latino ☐ Other

Emergency Contact Name & Phone Number _____

Next Of Kin _____

Advance Directive: ☐ Yes ☐ No ☐ Unknown

Primary Care Provider _____

Form Completed By _____

*Remember to copy the patient's **Insurance Cards** and **Driver's License** of person responsible for the bill!*
If it is a Motor Vehicle Accident, we need auto insurance. If patient is Hospice, we need Hospice Information.

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Retired

Employer Name _____ Phone _____

Work- Related Accident: ☐ Yes ☐ No Auto: ☐ Yes ☐ No Date of Accident/Injury _____

Insurance _____ Policy Number _____

Insurance _____ Policy Number _____

If Patient is a Minor:

Guarantor _____ Relationship to Patient _____

SSN _____ DOB _____ Gender: ☐ M ☐ F

Phone Number _____ ☐ Home ☐ Cell ☐ Message

Mailing address _____

Physical address _____

Employer Name _____ Phone _____

PO Box 66 • 1208 6th Avenue East • Superior MT 59872
Phone (406) 822-4803 • Fax (406) 822-3848
www.MineralCommunityHospital.org