

**MOUNTAINVIEW MEDICAL CENTER
PO BOX Q
WHITE SULPHUR SPRINGS, MT 59645**

Thank you for taking the time to complete this form. The information is necessary for the preparation of your Medical Records.

Medical Record # _____

Patient Name _____ PO Box # _____

Physical Address _____

City _____ State _____ Zip _____

Phone # _____ Cell _____ Social Security # _____ Race _____

Sex _____ Marital Status _____ Birth Date _____ Ethnicity- Non-Hispanic/ Hispanic

How may we contact you? Telephone _____ Letter _____ Email address: _____

Responsible Party (if minor) _____ Soc. Sec. # _____

Address _____ Birth Date _____

Employed by _____ Phone # _____

Employer's address: _____

Spouse's Name _____ Soc. Sec. # _____

Spouse's DOB _____ Spouse's Employer _____

Notify in Case of Emergency _____ Relationship _____
(Next of kin not in household)

Address _____ Phone # _____

City _____ State _____ Zip _____

Insurance Co. _____ Policy # _____
Group # _____

Insured's Name _____
Insured's DOB _____

Secondary Insurance Co. _____ Policy # _____
Group # _____

I authorize payment of medical benefits to undersigned physicians or supplier for service described. I understand I am responsible for payment or co-payment if I have insurance. Mountainview Medical Center will submit insurance billing. I hereby consent to and authorize all treatment that may be considered necessary or advisable by the physician(s) / physician assistant(s).

Signature _____ Date _____

If patient is a minor, I consent to and authorize all treatment may be considered necessary or advisable by the physician(s) / physician assistant(s)

Signature _____ Relationship _____ Date _____