Mountrail County Health Center
Many Avenues - One Goal...Your Health

LAST NAME **FIRST NAME** **MIDDLE NAME**

○ **MALE** ○ **FEMALE**

SEX **DATE OF BIRTH** **SOC SEC #**

MAILING ADDRESS **STREET ADDRESS** **ZIP CODE** **CITY** **STATE**

HOME PHONE **MOBILE PHONE** **WORK PHONE** **PATIENT EMAIL**

CONTACT PREFERENCE: ○ HOME PHONE ○ WORK PHONE ○ MOBILE PHONE ○ MAIL ○ PORTAL

RESULT DELIVERY PREFERENCE: ○ PAPER ○ PHONE CALL

LANGUAGE:

RACE: ○ ASIAN ○ BLACK OR AFRICAN AMERICAN ○ WHITE ○ AMERICAN INDIAN ○ NATIVE HAWAIIAN ○ HISPANIC OR LATINO

ETHNICITY: ○ HISPANIC ○ NON-HISPANIC

MARITAL STATUS: ○ MARRIED ○ SINGLE ○ DIVORCED ○ SEPARATED ○ WIDOWED ○ PARTNER

GUARDIAN:

LAST NAME FIRST NAME RELATIONSHIP PHONE NUMBER

EMERGENCY CONTACT:

LAST NAME FIRST NAME RELATIONSHIP PHONE NUMBER

NEXT OF KIN:

LAST NAME FIRST NAME RELATIONSHIP PHONE NUMBER

EMPLOYER:

COMPANY NAME CITY STATE PHONE NUMBER

POLICY HOLDER:

RELATIONSHIP TO PATIENT: (PLEASE CIRCLE ONE)
SELF SPOUSE CHILD GRANDPARENT FOSTER CHILD
EMPLOYEE FATHER MOTHER OTHER:_____

LAST NAME FIRST NAME DATE OF BIRTH

MAILING ADDRESS CITY STATE ZIP CODE

SOCIAL SECURITY NUMBER PHONE NUMBER EMAIL

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GUARANTOR/RESPONSIBLE PARTY:

RELATIONSHIP TO PATIENT:
(PLEASE CIRCLE ONE)

SELF SPOUSE CHILD GRANDPARENT FOSTER CHILD

EMPLOYEE FATHER MOTHER

SAME AS POLICY HOLDER OTHER:_____

LAST NAME	FIRST NAME	DATE OF BIRTH
MAILING ADDRESS	CITY	STATE ZIP CODE
SOCIAL SECURITY NUMBER	PHONE NUMBER	EMAIL