Bluestone Vista
PROVIDED BY Mankato Clinic
ON-SITE PRIMARY CARE

Patient Enrollment Form

PATIENT NAME/INFORMATION: *Please use full legal name*

☐ Male
☐ Female

LAST: _____ FIRST: _____ MI: _____ DOB: _____/_____/_____

☐ Memory Care
☐ Assisted Living

ADDRESS: _____

FACILITY: _____

☐ Facility Staff
☐ Family /Caregiver
☐ Self/Patient

SOCIAL SECURITY #: _____/_____/_____ Medications Managed by:

RACE/ETHNICITY: *Choose one or more* ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic or Latino
☐ Black or African American ☐Native Hawaiian/Other Pacific Islander ☐ White ☐ Declined ☐ Unknown

PRIMARY LANGUAGE SPOKEN: _____ COUNTRY OF ORIGIN: _____

INSURANCE INFORMATION: *Please include front & back copies of ALL insurance cards*

PRIMARY PLAN NAME: _____

PRIMARY POLICY/ID #:_____ PRIMARY GROUP #:_____

SECONDARY PLAN NAME: _____

SECONDARY POLICY/ID #:_____ SECONDARY GROUP #:_____

HEALTHCARE DECISION MAKER: *Provide copy of Health Care Directive, Medical POA or Guardianship*
☐ *No Legal Representative, Health Care Directive or Medical POA*

Name: _____ Relationship to Patient: _____
Primary Phone#:_____ Secondary Phone #:_____
E-Mail Address: _____
**We'd like to email you valuable information about Bluestone. Please indicate the email address you'd like us to send the information to.

BILLING CONTACT:
Name: _____ Relationship to Patient: _____
Primary Phone#:_____ Secondary Phone #:_____

NAME OF PERSON COMPLETING THIS FORM: _____

RELATIONSHIP TO PATIENT: _____ **PHONE #:** _____ **DATE:** _____

Please be sure to register for communication access on the Bluestone Bridge
**Copy of Health Care Directive, Medical POA (long form POA), Guardianship or signed consent by patient required*

https://mankato.bluestonebridge.com