***Medications must be managed by facility and patient must receive facility nursing services to be eligible to enroll in Bluestone Vista services.***

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

□ Male

□ Female

□ Other

LAST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIRST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

ADDRESS: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

*NOTE: This is where you want all communication sent (medical results, letters, billing statements, etc.)*

□ Memory Care

□ Assisted Living

□ Group Home

FACILITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_\_

RACE/ETHNICITY: □ American Indian/Alaska Native □Asian □Black/African-American □ Hispanic/Latino

*Choose one or more* □ 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_POLICY ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PRIMARY GROUP #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SECONDARY PLAN: POLICY ID#: PRIMARY GROUP#:

**HEALTHCARE DECISION MAKER:**

□ Self

□ Legal Representative - *Must provide copy of Health Care Directive, Medical POA or Guardianship*

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:**

□ Same as Healthcare Decision Maker

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If Legal Representative is signing this form:** I acknowledge and agree that by signing this form as a Legal Representative for the patient, I swear and attest that I am legally authorized to act and make decisions on behalf of the patient. I am required to provide a copy of valid and effective documentation outlining my role as Legal Representative.

Patient Signature: Date:

Legal Representative Signature (*if authorized to sign for patient)*:

Legal Representative Printed Name: Date:

Fax completed forms to: 507-385-4186