Patient Registration Form

Photo ID & Insurance Cards (if applicable) are required.

SAVE PRINT

98point6 Emergicenter

Patient Demographics

First Name | Last Name | Suffix | Preferred First Name

Permanent Address | Apt # | City | State | ZIP

Home Phone | Work Phone | Cell Phone | Social Security Number

Birthdate | Age | Gender | Marital Status

May we contact you by email if needed? ☐ Yes ☐ No

Email Address

May we contact you at the phone numbers provided? ☐ Yes ☐ No

Have you ever been treated at 98point6 before? ☐ Yes ☐ No

How did you hear about us? ☐ Friend ☐ Doctor Referral ☐ Internet ☐ Radio ☐ Brochure

☐ Other _____

Chief Complaint

Please describe what you wish to be seen for today.

Emergency Contact Information

Contact Name | Contact Phone | Relationship to Patient

Responsible Party Information

Responsible Party's Legal Name | Address (if different than above) | Phone

Responsible Party Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Responsible Party Employer | Employer Address (if known)

Primary Care Physician Information

Primary Care Physician | Phone (if known)

Medical Insurance Information

All info is required to process your claim

Primary Insurance | Policy Holder's Employer | Secondary Insurance | Policy Holder's Employer

Primary Policy Holder's Legal Name | Birthdate | Second Policy Holder's Legal Name | Birthdate

Primary Policy Holder's Relationship to Patient

☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Secondary Policy Holder's Relationship to Patient

☐ Self ☐ Spouse ☐ Parent ☐ Other _____

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