

Patient Information (please print)

Picture Identification is required

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		
Birth Date	Age	Gender	Marital Status	Email address	
Have you been treated at 98point6 Emergicenter before?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
May we contact you, if needed, via email?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
How did you hear about 98point6 Emergicenter?		<input type="checkbox"/> Friend	<input type="checkbox"/> Dr. Referral	<input type="checkbox"/> Internet	
		<input type="checkbox"/> Radio	<input type="checkbox"/> Brochure	<input type="checkbox"/> Other _____	

CHIEF COMPLAINT

Please describe what you wish to be seen for today

EMERGENCY CONTACT INFORMATION

Contact Name	Contact Phone	Relationship to patient
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RESPONSIBLE PARTY INFORMATION

Responsible Party's Legal Name	Address if different than above	Phone
Responsible Party Relationship to Patient	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____	
Responsible Party Employer	Address if known	

PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician	Phone if known
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MEDICAL INSURANCE INFORMATION (all information is required to process your claim)

Primary Insurance	Policy Holder's Employer	Secondary Insurance	Policy Holder's Employer
Primary Policy Holder's Legal Name	Date of Birth	Secondary Policy Holder's Legal Name	Date of Birth
Primary Policy Holder's Relationship to Patient	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____	Secondary Policy Holder's Relationship to Patient	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____

Thank you for choosing 98point6 Emergicenter